Abortion Assessment Project of India

Qualitative Studies

A REPORT

CEHAT

HEALTHWATCH TRUST

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CEHAT
Mumbai

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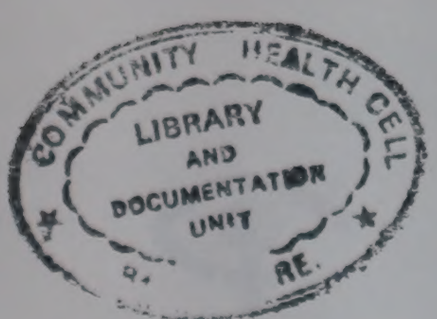

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Abortion in India

Overview and Synthesis of Emerging Issues from the Qualitative Studies

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THE BACKGROUND

Abortion Scenario in India

Abortion remains a sensitive issue in most countries of the world, and has only recently received international attention as a public health issue. India pioneered in legalising induced abortion under the Medical Termination of Pregnancy (MTP) Act of 1971. Abortion can be legally availed if a pregnancy carries the risk of grave physical injury to a woman, or endangers her mental health, or when pregnancy results from a contraceptive failure in a married woman, or from rape, or is likely to result in the birth of a child with physical or mental abnormalities. Abortion is permitted up to 20 weeks of pregnancy duration and no spousal consent is required. The Act and the subsequently defined MTP Rules of 1975 also clearly specify who can legally perform the abortion and the kind of facilities in which it can be performed (GOI, 1971; GOI 1975).

Information on the number of abortions performed every year in the country is difficult to compile because a large proportion of abortions is performed either by practitioners who are not registered or in settings that are not registered, or both. According to the Ministry of Health and Family Welfare, in 1996–97 about 4.6 lakh MTPs were performed in the country (MOHFW, 1997). Against that, an estimated '6.7 million abortions per year are performed in other than registered and government recognised institutions, often by untrained persons in unhygienic conditions' (Khan et al 1998).

After the initial attention on unsafe abortion in the 1960s and early 1970s that was the driving force behind legalisation, public discussion in India on abortion-related morbidity and mortality has been practically absent, and despite an intensive national campaign for safe motherhood, the issue of abortion has not captured public attention. Although the review of literature done during the preparatory planning phase of the Abortion Assessment Project–India (AAP–I) in 1998 indicated that 'morbidity and mortality from unsafe abortion remains a serious problem for Indian women 28 years after abortion was legalised in India' (Johnston 1999), data on abortion-related morbidity have been scant and there are some indications that mortality due to abortion procedure has decreased over time. In the last decade, women's health advocates have tried to draw the attention of policy-makers and administrators to a range of issues related to abortion in order to improve the availability, safety and use of services. From the perspective of both the providers and the clients, some of the concerns that have been raised in recent years are:

- Abortion is perceived as an extension of the government's population stabilisation programme.
- Safe abortion facilities are out of reach for the majority of women in rural areas and also for poor women in urban areas.

- There is a dearth of medically approved abortion providers and registered facilities.
- Post-abortion family planning counselling and services are woefully inadequate.
- Abortion is not perceived as a women's health issue among policy-makers and service providers.
- Abortion is often used as another method of family planning.
- There is a growing trend in many regions of India towards sex-selective abortion.

For almost forty years, despite officially advocating the 'cafeteria approach', the main thrust of India's family planning programme was on sterilisation (male sterilisation until 1977 and female sterilisation since 1978). As a result, the contraceptive needs of those who are not ready for a permanent method of contraception and of unmarried women have received very little attention. The needs of unmarried couples have unfortunately been caught in the debate on the ethical and moral issues of premarital sex and promiscuity. Given the volatile nature of this issue, especially in a world where ethnic, religious and community identities are gaining greater legitimacy in politics, concerned individuals have shied away from initiating or participating in a public debate on abortion. Some argue that this may end up in setting the clock back and that women will face a set-back in reproductive rights.

In the post-Cairo period, Government of India decided to remove method-specific contraceptive targets in 1996, and to introduce more comprehensive Reproductive and Child Health (RCH) programmes in place of vertical safe motherhood, child survival and family planning programmes, in 1997. This gave women's groups and advocates an opportunity to re-establish the importance of a holistic approach to women's health. Donors supporting the government's efforts (World Bank, European Community, Swedish International Development Cooperation Agency [SIDA], DANIDA and DFID) highlighted the importance of looking at abortion-related mortality and morbidity as a part of the RCH package. This created a favourable climate in the country and provided an impetus to various stakeholders to examine the issue from different dimensions and work towards making abortion safe. In the last several years donors have been working with the Government of India and various state governments to develop district-specific plans for Reproductive and Child Health programmes. These efforts have been noteworthy and administrators are trying to grapple with hitherto unexplored public policy issues.

While the climate seems to be favourable to initiate debate on safe abortion among key stakeholders, lack of reliable information, wide regional and rural–urban differences and a thin research base make it difficult for policy-makers, administrators and women's health advocates to develop strategic interventions. There is little dialogue between different stakeholders, and it is not uncommon to see registered service providers, unregistered/untrained practitioners, women's health advocates, those who continue to believe in population control, public health advocates and others working at cross purposes. While the moderates in all the above constituencies are open to dialogue and change, it is indeed a big challenge to bring them together in a non-confrontational forum.

Abortion Assessment Project–India

As a first step, the Abortion Assessment Project–India (AAP–I) has ventured to fill the gap in our understanding of the ground reality with respect to induced abortion and to create an evidence-based body of knowledge. The project, designed as a multicentric research study, commenced in August 2000 and was managed jointly by CEHAT (Mumbai) and HealthWatch (New Delhi). The main objectives of the project were:

- To review government policy towards abortion care, availability of funds, their flow and the policy/programme environment in the country—including family planning and abortion care;
- To assess and analyse abortion services, including organisation, management, facilities, technology, registration, training, certification and utilisation in the public and private sectors;
- To study the user perspective with special focus on women's perceptions of quality, availability, accessibility (including barriers to utilisation of safe abortion facilities), confidentiality, consent, post-abortion contraception and the attitude of service providers;
- To study the social, economic and cultural factors that influence decision-making, the impact of changing social values, male responsibility, family dynamics and decision-making;
- To document costing and finance issues related to the above; and
- To estimate the rate of abortion, resultant morbid-

ity and mortality and reasons for induced abortion.

In order to address the above objectives, the project laid out five components or activities, namely:

(i) Preparing an overview paper on policy-related issues as well as a series of working papers based on existing data/research, and conducting workshops to pool existing knowledge and information (*Component I*).

(ii) Conducting a multicentric facility survey in six states representing the main regions of the country (*Component II*).

(iii) Undertaking eight qualitative studies on specific issues to complement the multicentric studies. (*Component III*).

(iv) Undertaking community-based studies to estimate abortion rates in two states in India (*Component IV*).

(v) Initiating a dissemination and advocacy programme after completion of research (*Component V*).

Component III was coordinated by HealthWatch and funded by MacArthur Foundation. CEHAT (Mumbai) coordinated Components I, II and IV, and they were funded by Ford Foundation and Rockefeller Foundation. The Secretariat of AAP–I was housed in CEHAT (Mumbai). Component V will be initiated after the dissemination of the findings emerging from the research-based activities.

HEALTHWATCH

In the period preceding the September 1994 International Conference on Population and Development, Cairo, a few individuals in India, representing different stakeholders, informally initiated a dialogue to assess and gauge whether the country was ready to remove contraceptive targets from the family planning programme. As a result of this process, diverse and often adversarial groups came closer during and after the Cairo conference, and created a non-confrontational forum for debate with the government. The Indian government's decisions to remove contraceptive method-specific targets and to introduce an integrated RCH programme were partly a result of this dialogue.

HealthWatch—a network of organisations and individuals committed to bringing about systemic changes in the government's health and family welfare programme—was a product of this 'dialogue' and came into existence in December 1994.[2] This network has made concerted efforts to sustain the dialogue, albeit on a low key. During the past decade it has been realised that creating and sustaining free and frank dialogue on women's health issues with the government and with donor agencies is a painstaking process where hard facts and reliable data are necessary. Small but evidence-based research studies highlighting qualitative issues pertaining to the implementation of the RCH programme, undertaken under the aegis of HealthWatch during 1997–98, proved to be extremely useful in bringing sensitive issues to the fore.[3] Similarly, it was recognised that in order to initiate a dialogue between various stakeholders and policy-makers and to acknowledge abortion as a public health issue, reliable and dependable data would be needed. HealthWatch along with CEHAT decided to undertake this ambitious endeavour.

QUALITATIVE STUDIES: PROCESS AND METHODS

In keeping with the expertise and interest of the HealthWatch network, qualitative research studies (Component III) were initiated to address some of the objectives listed above. At the outset, HealthWatch initiated a series of formal and informal discussions based on a concept note prepared by T.K. Sundari Ravindran,[4] to agree on a broad framework for commissioning the qualitative studies. After the discussions, the following specific themes were identified for possible further exploration and in-depth research, to enhance our understanding of some of the abortion issues:

- Perspectives of seekers and providers with respect to unwanted pregnancies and quality of abortion care;
- Linkages between contraceptive practices, services and abortion;
- Women's rights and reproductive rights in the context of abortion;
- Post-abortion care and counselling.

HealthWatch constituted a small sub-committee (Project Advisory Committee) to screen the proposals, provide technical support to the agencies and individual researchers undertaking the studies, and also to try and ensure that the studies were done in accordance with the agreed framework and guidelines. The members of this committee included nominees of the HealthWatch Steering Committee, researchers and professionals having expertise on reproductive health issues.[5]

HealthWatch adopted a transparent and democratic

process for selection of research partners. A call for proposals was advertised in the *Economic and Political Weekly, Seminar, HealthWatch Update, Chetna Newsletter*, and through select e-mail networks. In response to the call, 45 proposals were received. The members of the Project Advisory Committee scrutinised each proposal, and shortlisted ten. The principal investigators of these ten research proposals were invited for a methodology workshop in Mumbai during 31 August–2 September 2001.[6] The proposals were reviewed, and from the revised versions submitted after the workshop, the studies were commissioned and funded.

In accordance with the guidelines of AAP–I all the partners were asked to constitute an institutional ethics committee to review the research tools and also ensure adherence to the ethical guidelines of the project. Projects used a range of qualitative methodologies that included in-depth interviews with women who had undergone induced abortions, key informant interviews with village leaders, men and service providers, and focus group discussions (FGDs) with a variety of respondent groups. One project in Pune (Morankar) used vignettes or abortion scenarios in order to stimulate discussion among study respondents. Some projects used structured survey instruments alongside the qualitative tools.

Table 1 lists the study area, respondents and objectives of each of the studies.

Analysis/Preparation of Reports

HealthWatch organised two workshops to assist the researchers in qualitative data analysis. This was done in collaboration with Bela Ganatra of Ipas, India. A review Committee was formed to critically review the draft reports. The aim was to provide feedback on the analysis of the data, documentation and on the contents of the reports. Each report was reviewed by at least two reviewers. The draft reports of the eight qualitative and of the informal providers were shared in a meeting held in Bangalore on 22–24 May 2003.[7] Based on the feedback, the researchers revised and finalised their reports.

ISSUES EMERGING FROM THE QUALITATIVE STUDIES

As indicated in the preceding section, the eight qualitative studies undertaken as part of the Abortion Assessment Project–India dealt with a range of abortion issues. Although all the studies employed various qualitative research methods, in some of the studies some quantitative data were also collected. In some studies both the providers and the clients were interviewed, in some just women (without ascertaining whether they had experienced or undergone abortion) were interviewed.

An effort is made in this section to highlight and discuss the evidence gathered by the various studies on a range of abortion-related issues. The broad issues under which the findings have been grouped are:[8]

- Reasons for seeking abortion
- Decision-making pathways
- Inter-generational differences in abortion seeking
- Selection of provider
- Abortion-related care including quality of abortion care
- Perspectives and views of abortion providers.

A Note of Caution

At the outset it is important to state that the eight qualitative studies were conducted in small geographic areas of a few relatively more developed states. As with all qualitative studies, generalisabilty beyond the immediate study area is an issue. Therefore the synthesis of findings does not apply to the entire country or even to the entire state in which the study was done, and the analysis needs to be interpreted with caution and within the context of the area studied.

Given the sensitivity of abortion and the ethical principles adhered to in AAP–I, the informed consent of respondents was important and all the researchers were required to obtain it from their respondents. As a result, with the exception of one of the Tamil Nadu studies (where sexuality issues were explored in focus group discussions [FGDs] with women regardless of their marital status at their workplace), unmarried and single women were not interviewed on abortion.

Most of the findings on unmarried women reflect the views of the married women during the FGDs, and represent community attitudes rather than actual behaviour or practices as well as the interpretation of the researchers. It is therefore not always easy to sift the views or perceptions of the researchers and that of the respondents, who in turn present their point of view about a sub-group.

In three of the seven studies social mobilisers /service providers of the partner NGO worked as field

Table 1: Geographical Coverage and Objectives of the Eight Qualitative Studies

Researcher, Organisation and Title of the study	*Geographical Area*	*Study population / Respondents*	*Main Focus of the Study*
S. Anandhi, Madras Institute for Development Studies *Women, Work and Abortion Practices in Chengalpattu District, Tamil Nadu*	Four villages in Kancheepuram District of Tamil Nadu	*Dalit* women (married and unmarried) working in pharmaceutical companies; village functionaries and opinion leaders; abortion service providers	Abortion decision making and practices in the context of increasing employment of rural women in industrial sector in peri urban areas
Alka Barua, Foundation for Research in Health Systems, Ahmedabad, *Study on Availability and Accessibility of Abortion Care, Gujarat*	Two urban slums in Ahmedabad	Married women with an induced abortion experience; Abortion service providers	Provider choice; women's perspectives on quality of abortion care; provider perspectives on accessibility and quality of abortion care
Leela Visaria, Gujarat Institute for Development Research, Ahmedabad, *Sex-Selective Abortions in Mehsana and Kurukshetra Districts of Gujarat and Haryana*	Six villages in Mehsana district in Gujarat; six villages in Kurukshetra district in Haryana	All currently married women in the age group 15–49; abortion service providers in Gujarat	Decision-making process and role of son preference in sex-selective abortions
S.N.Morankar, Maharashtra Association for Anthropological Sciences, Pune, *Ethnographic Exploration of Abortion and Abortion Care Related to Community Needs in Velhe Block of Pune, Maharashtra*	Fourteen villages in Pune district, Maharashtra	Married women and men from the community; opinion leaders; service providers	Ethnographic exploration of community attitudes around abortion
M.Prakasamma, Academy for Nursing Studies, Hyderabad, *Post Abortion Care through the Public Health System, Andhra Pradesh*	Three villages and selected public health facilities in Medak district, Andhra Pradesh	Women with a spontaneous or induced abortion; service providers both doctors and mid-level providers (ANMs); facility assessment	Role of the Public Health system in care for women during and after abortion (both spontaneous and induced)
Anjali Radkar, Independent Researcher, Pune, *Abortion in Rural Community near Urban Areas, Maharashtra*	Two peri-urban villages near Pune, Maharashtra	All currently married women in the 15–49 age group	Decision-making and provider choice
T.K. Sundari Ravindran, RUWSEC, Chengalpattu, Tamil Nadu, *Processes and Factors Underlying Choice of Induced Abortions: A Qualitative Investigation in Rural Tamil Nadu*	98 hamlets from the RUWSEC project area in Kancheepuram district of Tamil Nadu	Low income, socially marginalised couples (both wives and husbands)	Gender dynamics and abortion decision-making; inter-generational differences in abortion-seeking behavior
K.Susheela and K. Nagaraj, Madras Institute for Development Studies, Chennai, *Abortions in Dakshina Kannada: Socio-Cultural* and *Medical Underpinnings* and *Consequences*	One village in the Udipi district, Karnataka	Women—Beedi workers and agricultural workers	Estimate the extent of pregnancy wastage (including spontaneous and induced abortions) and socio-economic, cultural and medical factors associated with it.

investigators, While this may have proved to be valuable in establishing a rapport with women and building a relationship of trust and familiarity, it can lead investigators to assume certain things and preclude probing.

Reasons for Seeking Abortion

The reasons for seeking abortion reported in the various studies ranged from proximate causes such as a desire to limit family size or space pregnancies, preference for a son, seeking abortion for medical reasons or availing it on medical advice to distal determinants such as poverty, violence and belief systems. The various causes as discerned from the studies are discussed.

Abortion for limiting family size and spacing

There were really no surprises; the overwhelming reason for seeking abortion—among married women was to limit the family size. When women were asked to indicate the situations in which they would seek abortion or had actually sought abortion, the majority of the women in the studies conducted in Maharashtra, Gujarat, Andhra Pradesh and Tamil Nadu reported limiting the family size as the main reason for abortion.

Similarly, a very short inter-birth interval or conception when the earlier child was too young was also cited as a reason for abortion. During postpartum amenorrhoea and while breastfeeding the child, some women may become pregnant and do not realise it. In order to avoid having another child in quick succession, women accept abortion as the only viable option. Among the younger women, according to Anandhi in a study in Tamil Nadu, frequent childbirth was viewed as shameful and abortion was used as a spacing method to increase inter-birth interval.

Another contraceptive-related reason for abortion that emerged in the studies from Tamil Nadu, Andhra Pradesh, Gujarat and Maharashtra, was conception soon after marriage. Although a premium is generally placed on proof of fertility and elders would like the young bride to bear a child within a reasonable time after marriage, conception almost immediately after marriage was reported as a reason for abortion by a few women. Interestingly enough, as reported by Barua in the Gujarat study, if girls who were married to non-resident Indians (NRIs) became pregnant soon after marriage, they opted for abortion because of the fear that an immigration visa may not be granted if they are pregnant and that they will not be able to join their husbands abroad.

Links between contraception and abortion

Non-use of contraception rather than contraceptive failure was reported to be the chief reason why the unwanted pregnancy situations described above tended to occur. Actual contraceptive failure was reported only in one study (Prakasamma in Andhra Pradesh), where for one respondent, tubectomy failure led to conception and subsequent abortion.

Gap between knowledge and use of contraception

Lack of knowledge about contraception was not an issue at all among the women in the regions where the studies were carried out. All respondents across studies reported knowledge of sterilisation as a method of limiting family size, and a majority of the women knew about reversible methods of contraception such as condoms, oral pills and IUDs for spacing births. But for a host of reasons this knowledge did not translate into actual practice. Thus, for example, in the RUWSEC study, 29 of the 66 women who were interviewed knew about reversible methods in some detail, but knowledge was usually based on information received through the health outreach activities of the programme and not on the actual lived experiences of people in the community. Ever-use of contraception was not low but many discontinued use or were irregular in their use.

The reasons for the persisting gap between knowledge and practice were explored in some of the qualitative studies. The reasons cited for not using contraceptives were:

- Fear of some of the contraceptive methods: the study conducted by RUWSEC in Tamil Nadu indicated that some women reported that they could not use oral pills or IUDs because of their sides-effects. It was also reported that women believed that oral pills '*dry up the blood in our body*', thereby preventing them from doing hard physical labour. An opinion was also expressed that use of oral pills '*is okay for urban women, but we rural women have to do a lot of physical labour.*'
- Irregular supply of oral pills was why some respondents did not use them and ended up becoming pregnant in the study conducted in Andhra Pradesh by Prakasamma.
- In some studies women admitted that while condoms were the safest method of contraception, the husbands did not always cooperate in using them. In the RUWSEC study, for example, it was reported that

men tended to be inconsistent and irregular in use of condoms or complained that condoms interfered with sexual pleasure.[9]

- There was also a perception articulated that IUDs led to pain and discomfort. This may be an outcome of the poor quality of care—especially if the IUD is inserted without proper pelvic examination or in settings where basic hygienic conditions are compromised and lead to infection.

Female sterilisation as first and final method of contraception

As indicated in some of the studies, women find the reversible or spacing methods of contraception inconvenient or unacceptable, and after giving birth to desired number of children, they opt for sterilisation. However, since the desired family size is measured in terms of surviving children, typically couples wait for a few years to ensure the survival of their children before accepting a permanent method of sterilisation. During this intervening period, if women become pregnant, some of them choose to abort the foetus. Thus abortion is resorted to for pregnancy that occurs while women are waiting to undergo sterilisation. Curiously, women who opted for abortion in such situations reported that it is a better option as compared to relying on the IUD or oral pills. Women also indicated that after abortion they did not require much rest and they could resume their daily routine work almost immediately (see Box 1: Radkar).

Low risk perception for becoming pregnant

Further, some women who have infrequent sexual contact either because their children are grown up or married, or because their husbands are often away for long periods, feel that occasional sexual contact will not lead to pregnancy. However, when they realise that they have become pregnant, some of them prefer to abort the foetus rather than bear a child.

Perception that abortion is safe

All the qualitative studies were conducted in states where availability of safe abortion services is fairly good, especially for married women. According to some of the qualitative studies, women also reported that abortion did not have any long-term adverse health consequences, and for some respondents it was seen as a 'safer' option than the use of IUDs and other spacing methods.

Box 1: Reasons for seeking abortion

When information on the reasons for abortion is collected, responses varied. In many cases the responses were multiple, as the reason for abortion is a complex phenomenon.

It was found that in 33 cases [out of 70 abortions reported by 65 women], the reason [for abortion] was limiting family size and in 17 cases abortion was for spacing between the children. . . . This finding is consistent with the widespread preference for smaller families in most Asian countries and with the fact that most abortions in the region are among married women.

Abortion was also sought because of the female foetus in the case of eight women. . . . Other reasons for abortion included problems for the mother: either problems in earlier pregnancies or general trouble during pregnancy. Two women reported heart trouble and one a prolapsed uterus as a reason for abortion. Weakness of the mother was the reason reported by five women. In three cases abortion was for economic reasons. In one case the reason given was, 'son was born already'. In a peculiar case, the reason mentioned was, 'husband wanted to get married again', and in another case the woman had an abortion because she got pregnant immediately after marriage.

Apart from these reasons, women also have to resort to abortion for some unforeseen reasons. As one woman reported, '*My husband had relations with some woman and he wanted to get married to her. He always used to tell me, You are dark. I don't like you.' When he knew that I was pregnant for a second time he ordered me to go in for abortion. When I refused, he said, " I won't be responsible for whatever happens to you later" and walked away. So I got it done.*'

Anjali Radkar, AAP–I Qualitative Study, 2003

Abortion for desired sex composition of children

While direct questions on sex-selective abortion were not asked in most of the studies, almost all the studies pointed out that couples and their extended family opted for abortion not only to limit family size but also for achieving the desired sex composition of children. The internalisation of preference for sons was so widespread that studies conducted by Barua, Radkar, Anandhi and Visaria all reported that couples resorted to female-selective abortions after undergoing a sex determination

test. The reasons for why sons were preferred were expressed in terms of support in old age, continuing family line (as expressed in a study conducted in Maharashtra by Morankar: 'giving heir is prime duty of women') and performing death rites.

Women talked about the availability of ultrasound facilities in almost all the areas. Also, almost all the women were aware that sex-selective abortion was illegal and admitted that they would go to different facilities for ascertaining the sex of the foetus and for abortion. Awareness of the new PNDT Act was quite high among women and service providers, while awareness of the details of the MTP Act was quite low. Group discussions invariably turned quite spirited when sex selection was discussed. While most of them admitted that sex-selective abortion was indeed illegal, they expressed helplessness as their status in the family and sometimes the very survival of their marriage depended on their ability to produce sons. Women talked about this openly and without any hesitation in almost all the areas. Although the discussion in most of the studies was in terms of perceptions and likely actions, Radkar's study in Maharashtra indicated that 8 out of the 70 abortions, or 11 per cent were reported as being sex-selective. She further reported that *in all the FGDs with men, women and adolescent boys and girls, it very clearly surfaced that women who go for sex determination follow it up with abortion of the female foetus. Everyone seemed to know at least some women who had done this.*" According to Barua's study in Gujarat, 10 out of 62 abortions, or 16 per cent, were performed after sex determination tests and confirmation of a female foetus.[10]

It was further revealed in a study conducted in Maharashtra by Morankar that when only female children were born or conceived, abortion was approved by the family and condoned by the community. Thus, for a mother of several daughters there was no social stigma associated with sex-selective abortion. Women from Gujarat and Haryana also reported that while they were not comfortable with abortion per se, when it was done for the sake of the family they accepted it.

In the RUWSEC study, only in two instances abortion was resorted to, to avoid a female birth. In one instance the woman underwent abortion because she already had several daughters and feared giving birth to one more daughter. In the other instance, the woman reported being beaten by her husband for delivering a third female child, and so aborted the next pregnancy.

Box 2: Female-selective abortion

A noteworthy finding for Gujarat was that overall, the preponderance of male children or deficit of girls increased as the birth order increased. Although the sex ratio of the first birth was greater than the normally acceptable range of 104–107 boys per 100 girls, by the time women had their fourth or higher parity child, the chances of it being female diminished greatly. Assuming that the sex ratio at birth (without any interventions) was around 950 girls per 1,000 boys, the deficit of girls increased to almost 25 per cent. . . . The situation in Haryana was very similar to that observed in Gujarat. Sex-selective abortion during the first pregnancy did not appear to be the norm and was not practised, but by the time women had their second or third child, almost 50 per cent more boys were born compared to girls. This preponderance of males or deficit of girls was observed more among women who were better educated, belonged to higher castes and whose families were landed. As in Gujarat, these women belonged to the dominant Chaudhury caste.

Leela Visaria, AAP–I Qualitative Study, 2003

Sex selection was a topic on which everybody seemed to have fairly accurate information; it was also a topic on which everyone had an opinion. Universally, all women were in favour of sex detection in cases where the couple had daughters but no son. All of them felt that a son is a must. When the discussion veered towards whether sex detection is right or wrong, one 40-year-old woman exclaimed: '*Why do you blame our women? Did they know earlier that the sex of the child could be detected before birth? It is the doctors who told us about it.*' But when we pointed out that there are many things that doctors advise, particularly in terms of antenatal care or the health of the mother and children, which the women do not heed, the reply was: '*A person takes whatever she likes in the advice.*'

Anjali Radkar, AAP–I Qualitative Study, 2003

Anandhi, on the other hand, reported that in her study area, as elsewhere in the country, the preference for a male child and therefore for sex-selective abortion is quite common. However, women generally did not seem to avail of new technologies for detecting the sex of the foetus. Instead, they seemed to rely on prevailing

myths for sex determination. For instance, if a girl was born with two circle marks on her bottom, it was believed that the next child born to that woman would also be a girl. Even though women agreed that the predictive power of such beliefs was questionable, many tended to rely on these for having an abortion. The doctors at the private clinics also confirmed that such beliefs were prevalent in the community and played some role in abortion. Also, women preferred to undergo sterilisation only after a male child was born. Further, if the male child was still young and the woman conceived again, she would not hesitate aborting the second child, in order to provide special care and attention to the male child.[11]

On 'medical advice'

The studies by Barua, Radkar and Prakasamma indicated that abortions were resorted to for medical reasons such as when a woman's life is threatened or when there is fear of malformation of the foetus. However, an interesting divergence in the reasons cited by women and by abortion service providers was noted in a study by Barua. While the providers indicated that they conducted abortions for medical reasons such as poor health of the mother, and that an ill-formed foetus was only rarely the reason for an abortion, a fair number of women who were interviewed in the study indicated that they resorted to abortion on 'medical advice'. It is a moot point whether the terminology used by women is a euphemism for sex-selective abortion. This could also be a way of rationalising the abortion-related decision-making and shifting the onus on to the practitioner.

Box 3: Abortion under 'medical advice'

Seventeen women [out of 62 women who were interviewed] whose pregnancies were terminated on medical advice said that the decision had been made by the doctor. About a fourth of the women in the sample reported that the decision for abortion was made either by the family members or the couples themselves. A fifth (12) said that the decision was their own and only four said that their husbands had told them to get the pregnancy terminated.

Abortions on medical advice were more common in SLUM–2 [inhabited by lower-income groups and where the nearest facilities were some distance away]. Most (15) of the abortions based on medical advice were from SLUM–2. All the terminations of pregnancy consequent to medical advice were reportedly because of health problems in the woman or the foetus.

Alka Barua, AAP–I Qualitative Studies, 2003

Economic situation, work and poverty

Poverty or poor economic situation of the family was cited as a reason for seeking abortion by the two Tamil Nadu studies and the Karnataka study.

The study done by Anandhi among pharmaceutical industry workers in Tamil Nadu revealed that almost all the industries employing young women insisted on a contract which clearly stipulated that they could not get married or get pregnant during their contract period. Given their vulnerability and low social status, women were reportedly subjected to sexual harassment by their supervisors. At the same time, the working environment and relative independence due to being away from home provided the opportunity to some of the young women working in the factories to develop relationships with men in the areas in which they lived. As observed by the author, one would assume that . . . women's work in the informal sector, such as in the pharmaceutical industry, might have enhanced their status within the family as main income-earners or as providers, but it has not empowered them as decision-makers in the domain of reproduction and sexuality. In these circumstances, women's decision to abort does not signify their autonomy or the free choice. However, in the specific context that we have so far described, the decision to abort by unmarried girls does emerge as an act of 'strategic accommodation'[12] or as a combination of both complicity and resistance. What is significant about the escalating rate of abortion among unmarried young women is that it coincides with their increasing employment in the industrial sector. The high incidence of abortion among them might appear as a conscious reproductive choice emerging from their role as providers in the family. Unfortunately, it is only a means for negotiating the disempowering conditions of their work and production relations.

Anandhi also found that for some women the pressure of child care and sole responsibility of supporting the family made them resort to abortion.

Although the Karnataka study interviewed women who were engaged either in beedi-rolling work or in agricultural work and who belonged to the lower socio-

Box 4: When is induced abortion acceptable?

A majority of the respondents appear to have what may be termed a liberal attitude towards induced abortions: more than 85 per cent know it is legal and close to 90 per cent do not want it banned. Close to two-thirds approve of taking recourse to induced abortions in a number of circumstances or contingencies. While one can perhaps expect that a majority of women would approve of taking recourse to abortion for reasons of mother's and child's health as also for pregnancies due to rape, what is perhaps surprising is that almost an equal proportion—nearly two-thirds—approve of it even in cases of pregnancies due to premarital or extramarital pregnancies. The reasons given for such approval were largely as follows: 'It may be true that the girl committed a mistake, but her life should not be ruined because of that mistake'; 'Life in this society for an illegitimate child is a very difficult one—and one should think of such a child's future life'; 'I have seen illegitimate infants abandoned immediately after birth; it is better to abort them than subject them to such treatment.'

While the overall attitude thus can be characterised as being fairly liberal, it is also interesting to note that it is *not*, what may be termed, permissive. This is clear from the attitudes towards access to abortions. . . . The reasons given for limiting the access were basically two. (a) It was felt that free access would encourage premarital and extramarital relations, which are morally not acceptable—they are still seen as 'mistakes' (b) The second reason given was much more pragmatic: free access would encourage repeated recourse to induced abortions, which, it was felt, was not good for the mother's health.

K. Susheela and K.Nagaraj, AAP–I Qualitative Study, 2003

economic segment of the population, the authors found that within these groups, the younger and more literate respondents underwent induced abortions to a greater extent than illiterate or older women. It is likely that the younger and more literate women are more exposed to the mass media and urban influences, which in turn influence their behaviour.

In the RUWSEC study conducted in Tamil Nadu, on the other hand, poverty compelled some younger women to resort to abortion. A concomitant reason given by some women was that they generally did not have any social support during and after the pregnancy. As one of the respondents said: *'I aborted two pregnancies, my third and fifth one. My family's economic situation was very bad at that time, and I was also not keeping well. He [husband] knew about the pregnancy and didn't say anything. But I decided. Only I knew the pain and the worries.'* Economic compulsion for women to work in order to make both ends meet was also cited as a reason for abortion. As one respondent who underwent induced abortion articulated, she had to support her husband to run their shop and the husband decided that they should terminate the pregnancy '*because I would not be able to stand all day in the shop during my pregnancy and that would affect the sales and our income.*'

Violence: physical and psychological

Several studies talked of women being pressurised into having an abortion (especially sex-selective abortions) by their husbands or conjugal family members. Pregnancy may accentuate domestic violence and if husbands are not too happy with the pregnancy (for example, later order births or if it is a girl child), physical violence may result (RUWSEC). When a woman gets pregnant, the husband may accuse his wife of being unfaithful as a way of demonstrating his power over her. The violence may be psychological or may turn to actual physical abuse as well. In Anandhi's study, several women reported that abortion was the only recourse in order to negotiate the cycle of domestic violence that another pregnancy would bring on. As one 38-year-old woman in her study narrated: *'After three girl children, when I conceived again I was afraid that this might also be a girl. Even that did not bother me as much as my husband's obscene remarks about my sexuality. For this reason, every time I got pregnant I tried to commit suicide. But this time I decided to abort the foetus. But the doctor advised me against an abortion, as it was too late to have it. So, I threatened the doctor saying that I would commit suicide right inside the hospital if she did not perform the abortion. Only then she agreed and aborted the foetus. But it turned out to be a male child. Still there was a pleasure in the abortion, as this time my husband could not suspect the child and me.'*

Women also sometimes reported using abortion as a way to settle a family dispute or to get back at their husbands or conjugal families. As one respondent in Barua's study mentioned: '*My mother-in-law and husband have been harassing and beating me since my mar-*

riage. Once when I was about four months pregnant, my husband, who was drunk at that time, beat me up. There and then I decided to abort the baby. The doctor did a sonography on his own and said that it was a male foetus and maybe I would like to continue with the pregnancy. But I was very clear in my mind. I got the abortion done without letting anybody know except my close friend.'

As the RUWSEC study highlighted, violence in the form of non-consensual sex plays a role in women becoming pregnant in the first place. Threats of violence, accusations of infidelity and loose sexual morals, as well as actual physical abuse are often used to ensure marital sexual relations even if they are against the women's wishes, and in most such sexual relations contraceptive use is also not likely. Some women in the RUWSEC study reported that their husbands compelled them to have sex saying that if there were a pregnancy, they would pay for the abortion. *'If I reject his desire to have sex, he says "It is me who will be meeting the expenses, if you conceive you can go for an abortion." But he doesn't realise the problems associated with abortions'* Many women made a direct link between non-consensual sex, unwanted pregnancy and abortion.

Myths about conceiving during inauspicious months

Another interesting finding of some of the studies—especially in Tamil Nadu—is that women cited conception during certain inauspicious months as a reason for abortion. The RUWSEC study also reported that there was a myth that a child born from a third pregnancy of a woman would not survive (three being an unlucky number). Therefore women becoming pregnant for the third time were forced to terminate the pregnancy. Sometimes, if the pregnancy coincided with some accident to the breadwinner or head of the family, it was perceived as an ill omen and the woman would be compelled to terminate that pregnancy. In one such case the woman was told: 'Is your unborn baby's life worth more than that of your husband?'

Such myths may be more widely prevalent in Indian society; however, no studies from areas other than Tamil Nadu made specific references to them. It would also be interesting to explore whether there are any inter-generational differences and changing sexual practices among younger women, who may be more exposed to education and the scientific basis of conception.

Abortion among single, divorced or separated women

None of the studies directly inquired about why or when women outside marriage resorted to abortion or whether having a child outside of wedlock is an option for some women. At the same time, in several of the studies this issue came up, and married women expressed their opinions on the need for abortion by women not in marriage. Three of the studies, in Maharashtra, Tamil

Box 5: Abortion among unmarried girls

Some respondents [in focus group discussions in response to a vignette about an unmarried girl becoming pregnant] thought that someone had exploited her and made her pregnant. Others felt that she must have consented to have sex with the man; if she hadn't, why had she not screamed for help when he was forcing her to have sex? What she had done was a sin and must be punished. The community does this by considering her unfit for marriage. However, most respondents (64 out of 77) did say that now that she has made the mistake, which led to pregnancy, she has no other alternative but undergo abortion unless, as 15 respondents pointed out, the man who is responsible for her pregnancy is of same or higher caste and accepts her as his wife.

These responses hold several implications for the issue of pregnancy and abortion among unmarried girls. Even when the boy is ready to accept the girl as his wife, the caste dynamics (26 out of 77) of the village might not allow it. If the boy were of a lower caste, marriage would not be acceptable to the girl's family and other caste members if the news about the pregnancy leaks out. As 53 respondents explained, the girl's parents or family members would prefer to keep the pregnancy under wraps and send the girl to a distant place for abortion. If the girl's pregnancy becomes public knowledge, the fear is that they will not be able to arrange a suitable marriage for her because the prospective groom's relatives would be sure to make enquiries about her character and the family's status in the village. The family would definitely think about the loss of their *izzat*, which, once damaged, cannot be recovered. Thirty-four respondents pointed out that community is very severe in its condemnation of a family whose daughter threatens the 'village *izzat*'.

S.N. Morankar, AAP–I Qualitative Study, 2003

Nadu and Andhra Pradesh, indicated that if a woman outside marriage became pregnant, then, in order to preserve family honour, she must abort the foetus. In the Maharashtra study, during group discussions, some of the women further opined that since such a pregnancy was a result of immoral behaviour of the woman or an act of sin, it had to be aborted. However, some of the respondents were sympathetic towards the women and conceded that pregnancy can result due to rape or violence caused by someone known to the woman. When such a 'mistake' occurs, abortion must be performed secretly and the mistake must be rectified in order to preserve the family honour. Overall, abortions outside the framework of marriage were characterised by secrecy, shame and stigma.

Decision-making Pathways

While the studies generally explored and attempted to identify the various socio-cultural factors that influence the decision to abort the pregnancy, a few collected information on the process involved before arriving at the decision for an abortion or exploring the pathways to decision-making. In his effort to unravel the socio-cultural meaning of abortion in varying settings (such as need for abortion by a married woman as distinct from that by a widowed or a single woman), Morankar used the vignette methodology to obtain textual data.

Radkar delineated the stages of decision-making once a woman discovers that she is pregnant. According to her, women first try out home remedies that they have heard of from their parents, such as eating fruits and foods that are considered 'hot'. Papaya, jackfruit and various concoctions made with ingredients considered hot are consumed. Some women reported that they also take headache tablets. If the menstruation does not resume after trying these methods, women may even attempt invasive methods like inserting a sharp instrument in their vagina and waiting for the bleeding to start. The textual data cannot establish the extent to which such invasive methods are practised in real life. Often possible ways, hearsay and actual facts get intermingled when women discuss the pathways to decision-making process leading to abortion. Interestingly enough, a few women in the urban Gujarat study by Barua reported that they directly approached the chemist for drugs for abortion and were provided them. This issue of availability of abortificient drugs with chemists needs to be probed further.

While it was quite evident from various studies that the decision-making process involved in seeking abortion was relatively easy for married women, this was not the case for women who conceived outside wedlock. Widowed, separated, divorced or never-married women typically first informed their parents or partners about pregnancy (Anandhi, Radkar, Morankar), who then generally decided whether and how to go about seeking abortion. In the case of an unmarried young girl who becomes pregnant, efforts are made by the parents of the girl to get her married to the boy who is responsible for her pregnancy. Morankar has explored in some detail how this is negotiated between the two families. When marriage is not a possible outcome the girl is generally taken to an informal provider, because there is a general perception that s/he would maintain secrecy and confidentiality much better. If the procedure fails or in the case of certain families whose economic condition is good the girl, is sent off for a few days to a faraway place and abortion is sought in a formal facility.

The situation of widowed or divorced women is somewhat different. If pregnancy occurs while the woman is residing with her in-laws, they would know about it. Even if the person responsible for the pregnancy is known or is a member of the family, the woman is blamed for it. Abortion is sought in order to preserve the 'honour of the village'. Responding to a hypothetical vignette, some respondents in Morankar's study even indicated that such women should commit suicide or leave the village.

Making decisions about abortion is both a dynamic and a complex process. Therefore, it is important to understand with whom women discuss their pregnancy, whom they consult or whose permission is sought for abortion, and who compels them to undergo abortion. Apart from factors such as caste, education, landholding or economic status that determine the process, the reason for which abortion is sought also plays an important role in who takes the decision. Several studies have addressed this issue. Radkar's study suggested that women themselves or jointly with their husbands made the decision about abortion in nearly half the cases, and husbands took the decision in the other half. At the same time, the extended family was very much involved in the decision-making process. As pointed out by one of the women: '*If they (family members,especially mother-in-law and sister-in-law) don't approve of abortion, how can I get the required rest? Who*

will look after my children when I am away in the hospital?

In the study conducted in Gujarat and Haryana, when women were asked about the decision-making process if they conceived a female child, the overwhelming response was that the pressure on them to abort was enormous from the extended conjugal family after one or two daughters. Women in both the states indicated that the decision to abort a female foetus was almost entirely that of their husbands and/or mothers-in-law. By themselves, women would not take the decision to go in for abortion. Women apparently accepted whatever their conjugal family, including husbands, desired and went along with the decision made for them by others. At the same time, some differences in the decision-making process were observed between women of higher social groups and of scheduled castes and other backward communities, with regard to the influence of in-laws in matters of decision-making about abortion. High-caste women had to inform and consult their in-laws but low-caste women had to obtain the consent of only their husbands for abortion. The influence of the extended joint family was not so strong for women from lower-caste groups. The role of the natal family was reported to be minimal in matters related to abortion or sex determination tests or sex-selective abortion. However, the Tamil Nadu study by RUWSEC reported that even when the decision to abort was taken by the women's husbands and parents-in-law, women were asked to approach their natal family for money or to pawn their personal assets such as jewellery to take care of the expenses, especially when the foetus was that of a girl.

Inter-Generational Differences

In a few of the studies, focus group discussions were conducted with both younger and older women to ascertain whether there were any differences between them with regard to various facets of abortion. Two studies which pursued the issue at some length were carried out in Tamil Nadu, although other studies also, in a somewhat limited manner, tried to understand the differences between younger and older women of reproductive ages.

Anandhi, who explored the experiences and perceptions of three generations of women in her study, indicated that abortion was fairly widely practised by women even before it was legalised. Older and middle-aged women did not seek abortion to limit family size, because large families were accepted as a norm and not as a burden or impediment to the standard of living. Abortion was perceived interms of women's desire to free themselves from child care responsibilities and was associated with female sexual desire, and the desire for abortion of a pregnancy at a later stage of married life was considered shameful and as dishonouring women. Others would make fun of women wanting an abortion saying that the pregnancy was a result of 'too much sexual desire', which was embarrassing.

In contrast, the younger generation of married women seemed to be using abortion as a spacing method not merely because it is permitted by law but also because of the change in notions of shame and honour. 'With the younger generation, it is not frequent pregnancy per se, that was once perceived as an expression of excessive female desire, but frequent childbirth, especially at the later stage of a woman's life, that was associated with the notion of shame.' Honour lay in

Box 6: Inter-generational differences in reasons for abortion

There were no differences between the younger and older age groups in the distribution of number of abortions per woman or the period of gestation when abortion took place.

Instances of women going for abortion without their husbands' explicit consent were far more common among the older age group (11/27 abortions) than among younger women (4/25 abortions).

Already I had five sons and my husband was not co-operative with me. His second wife also had two children. Taking in to all these I decided to abort and informed him. But he didn't agree. Then I went to my mother's home and had the abortion. My parents paid for all the expenses.

There were a range of different reasons given by women for terminating a pregnancy, although the most common ones, predictably, were to limit family size either because they had achieved their desired family size or for economic reasons; and to have a longer birth interval.

In contrast, the most common reason given by younger women was 'economic circumstances' and 'poverty' (10 abortions). A concomitant reason given by some women was that they would not have any social support during and after the pregnancy.

Balasubramanian et al., AAP–I Qualitative Studies, 2003

having fewer children and women were not ashamed of their sexuality.

The study undertaken by RUWSEC in the same geographical area, on the other hand, examined separately the abortion experience and perceptions of women (and the husbands of some of them) below 35 years and above 35 years of age. The study observed that instances of women going in for abortion without their husbands' explicit consent were far more common among the older women (11 out of 27 abortions) than among younger women (4 out of 25 abortions).

At first glance, the findings of the RUWSEC study are seemingly the opposite of that of the study conducted by Anandhi with regard to reasons for abortion among older and younger women. Unlike in Anandhi's study, older women in the RUWSEC study mentioned that they opted for abortion 'to limit the family size'. A concomitant reason was that their children were teenagers or adults and that they felt embarrassed to continue with the pregnancy or that they could not afford any additional children. Looking deeper, however, it is quite likely that the embarrassment of becoming pregnant beyond a certain age that women in the RUWSEC study mentioned could be due to this being seen as an expression of women's sexuality. However, instead of articulating it in those terms, as the women in Anandhi's study did, women may have chosen to express this in terms of limiting family size.

Selection of Provider

It is quite likely that since the studies were carried out in relatively more developed states of the country (and several were located in peri urban areas), most women reported that they went or would go to qualified private doctors / institutions or government facilities for abortion. Although not explored in depth, most respondents did point out that the unmarried, separated and widowed women often preferred or were taken by their family members to informal providers because of the desire for confidentiality and secrecy.[13]

Women generally come to know of the provider through word of mouth from friends and relatives, paramedical workers in the community or from other knowledgeable community members. Advertisements in public places like buses or in the newspapers seem to play a role in urban areas. Morankar's study in Maharashtra found that: 'this information is usually sought under the pretext that someone else needs it. Women gather this information from other women when walking to the river to wash clothes, while working in the fields, or while fetching water. Men get such information during gossip sessions with friends.'

Preference for private providers

The major determinants of choosing the provider by married women were his/her reputation, vicinity, familiarity and cost. There was an overwhelming perception that private facilities, where one could obtain services in much less time, were better. The range of reasons for preference for private providers was quite wide suggesting that the women and their families do weigh the alternatives before deciding where to go.

The reasons cited by the women were:

- Abortion in a private facility takes much less time—everything is done in one visit. According to Barua, women in urban Gujarat also preferred private providers and those that did not insisted on prolonged hospital stay. According to some of the women in her study, in public hospitals 'a lot of time is wasted in waiting and going through formalities; these hospitals are not client-friendly and the quality of services is suspect'. Radkar also reported that the quality of care and duration of time needed to be spent at the provider's facility were major considerations in the selection of the provider.
- Private doctors have better facilities and equipment.
- Private doctors are not in a hurry to discharge women soon after the procedure if they need rest for an hour or so before going home; in public hospitals, on the other hand, there is a shortage of beds and so women are asked to leave as soon as possible.
- Private doctors treat women better than government doctors.
- Private doctors generally ensure confidentiality.
- Unmarried women also preferred private providers if they could afford their services.

The exceptions reported were when women wanted to undergo sterilisation along with the abortion. In such instances, the women chose a government hospital where the acceptance of sterilisation would mean that the abortion did not cost them anything. Also, when the family was poor and could not pay for an abortion, a government facility was the option.

Those women who wanted to know the sex of the foetus and to abort the female foetus also preferred private providers. While the government facility would not

conduct sex determination tests but only provide abortion services, private facilities in some regions of the country provide both services along with maintaining secrecy. In the Gujarat and Haryana study, a majority of the women knew the towns where the private doctors with nursing or maternity homes provided these services, and also indicated that they would use them if the need arose.

Cost considerations

It was accepted that while the services of private providers cost money, visits to the government hospitals were not cost-free because the women had to pay for medicines separately. They were also sometimes required to make repeat visits before the abortion was performed. The long waiting period implied that the time of the service seeker and of the accompanying person (generally women do not go alone to large impersonal facilities) was wasted, and in poor families it meant foregoing wages for that duration.

The cost varied according to the type of provider and the gestation period. In the Andhra Pradesh study, a majority of the women who were interviewed selected the government hospital for abortion because of their poor economic status and also because they thought government services were free. However, after going to the hospital they realised that the doctors charged a fee for performing abortions. The average fee that women had to pay the doctor for abortion in a government hospital was a little over Rs 600. As shown in Table 2, Barua reported that in urban areas of Gujarat, the government-run tertiary hospital, though not free, was the cheapest, and private gynaecologists were the most expensive and they charged according to the duration of the pregnancy. According to Barua, the costs of the procedure in private facilities in urban Gujarat varied between Rs 400–600, not much different or higher than what women in urban Andhra Pradesh had to pay. Interestingly enough, the local NGO that the team visited charged nearly fifteen times the fees it advertised.

Table 2: Cost of Abortion in Gujarat

Facility	*Cost in Rupees*
Nurse	500–700
General practitioners	700–1000
Private gynaecologists	1st trimester: 750–1500 2nd trimester: 2500–5000
Local NGO	1st trimester: 350–400 2nd trimester: 1500–2000
National NGO	1st trimester: 400 2nd trimester: 800
Tertiary hospitals	Free–300

Source: Alka Barua, AAP–I Qualitative Study, 2003

It was evident during the focus group discussions that a certain group of women and their families calculate the cost of abortion in a somewhat different way, especially if the decision is to abort a female foetus. The immediate cost of abortion (including that of the sex determination test) is compared with the expenditure that would have to be incurred in future on dowry payment to the girl, if allowed to be born, at the time of marriage and on several occasions after marriage (Visaria).

Quality of Care

All the qualitative studies collected information from the participating respondents about the place and the provider of abortion, their expectations from abortion services and, where applicable, their experiences with them. Barua's study in Gujarat focused extensively on provider perspectives. Abortion service providers, both private and public, paramedical workers and village-level providers involved in referral of cases were interviewed as key informants in the four studies conducted by Prakasamma, Visaria, Anandhi and Morankar. In addition, Prakasamma's study included a facility assessment and some observations of client–provider interactions.

Urban women in Gujarat indicated that no preliminary tests, other than sonography for foetal sex determination, were done before the procedure. The latter was done only on the request of the client. In the urban Gujarat study, the providers also reported that they do not carry out any physical or internal check-up of the clients who come to them for abortion, relying instead on the date of missed periods as reported by the clients. Some of them did report doing a urine pregnancy test prior to pregnancy termination and several mentioned that clients often get this done before coming to them for an abortion. The government tertiary hospital was an exception, where several laboratory investigations including blood grouping were routinely carried out.

Further, in spite of the availability of safer and relatively simple methods of conducting abortion, and the providers having knowledge of them, the urban Gujarat study pointed out that they continued to use older

techniques for a variety of reasons. Among private providers, the method of choice was D&C or dilation and curettage. The Andhra study reported that three out of four doctors at the government hospital also used D&C as the main method for first trimester abortions. Key informants in Tamil Nadu too reported that most abortions were done by D&C. The choice was governed by factors such as convenience and experience of the provider with the method. Providers also referred to factors such as erratic electric supply, which make use of the electric vacuum aspiration method difficult. Manual vacuum aspiration was not considered to be an alternative in these situations by many providers, who believed that this method was not recommended beyond eight weeks of gestation. It was also reported that some providers who used manual vacuum aspiration, used D&C in addition to ensure that the abortion was complete.

Providers in Ahmedabad expressed awareness about medical abortion and several mentioned that they had used RU 486 (Mifepristone) or had treated patients who had taken the drug elsewhere and then come to the provider. The use of this method was not specifically mentioned in the other studies.

Box 7: Care during and after abortion

Providers said that when women come for abortion services they first ask the reason for abortion, and only if it is appropriate and if it is in the first trimester do they suggest abortion for unmarried women. In other cases service providers said they try to convince women to continue the pregnancy and use family planning methods to prevent the next pregnancy. The doctors also said that they first check the health condition of the woman.

They mentioned checking for bleeding, fever, white discharge, giving advice on personal hygiene, complete rest and family planning methods as post-abortion services. . . . All the doctors said that they prescribe HB and urine tests, and if the patient can afford it and is willing they ask for CTBT, grouping, HIV and blood sugar tests. All but one doctor said they conduct the HB test before discharge. One doctor said they check PV. Another said they check for urine passage and effect of sedation.

All the doctors said they use local anaesthesia irrespective of the length of gestation and that they use general anaesthesia only when necessary. Three of the four doctors said that they themselves gave local anaesthesia to the women and they take the help of a nurse or anaesthetist if general anaesthesia is required.

The doctors said that they advise personal hygiene and regular use of medicines to women before discharge. Three out of the four advised family planning methods and one doctor also advised women not to have sexual intercourse for five days. They also advised women to come within a week of the abortion for a follow-up.

M. Prakasamma, AAP–I Qualitative Studies, 2003

Counselling

Pre- or post-procedure counselling appeared to be limited in scope and content. Women in Ahmedabad reported that they were rarely given any details about the procedure. At the same time, it was seen that the women themselves were not interested in knowing the details. Their main concern was to get the procedure over with and leave as soon as possible.

Even though most of the abortions were reportedly sought for family size limitation, the private doctors apparently did not engage in counselling. Their perception was that the clients were not interested in it. Also, they do not have '*dedicated staff or incentives to do contraceptive or consequence-related [of abortion] counselling. Further, there is no audit system for counselling in hospitals.*' Whatever counselling is done tends to be limited to impressing upon frequent users of abortion, the consequences of repeat abortions (Barua).

Coercive contraception was not found in the public hospitals; it did not appear to be a common practice either in the tertiary care hospital in the Ahmedabad study or the public hospital that was included in the Andhra Pradesh study. The providers reported that they did not insist on the clients accepting family planning methods. The clients also reported that they were not coerced into accepting contraceptives. In fact, as one provider of a public facility admitted in Gujarat: '*As such, most providers in government hospitals do not have much time to spend with the client, so counselling is not effective.*'

Women in Andhra Pradesh who used abortion services from the government hospital expressed satisfaction with the procedure of abortion, the medication given to them, the bed and the availability of toilet facilities. They were not happy with the diet and water because food is not provided in the hospital and the family has to arrange it from outside. Availability of

Box 8: Quality of care: perspective of providers

The providers admitted that the pre-abortion services consisted primarily of physical examination, enquiries about medical and obstetric history. They did not do any internal check-up or ask for any investigations as these put the women off. They depended on the history of amenorrhoea, positive urine test or sonography report and consent of the woman and in case of anticipated problems, the presence and consent of relatives or accompanying persons. Except the government tertiary hospital the other providers did not think that any pre-abortion services were warranted or were mandatory. The medical officer from government tertiary hospital was a sole exception who mentioned that even a blood group test was necessary, as Rh-negative woman would need an anti D injection even after an abortion.

When specifically asked about why they asked for consent of people other than the woman when it is not mandated under the Act, the medical officer at the National level NGO said, "*Every surgical procedure, however minor, has the potential of becoming complicated. We do not insist on consent of the accompanying person, but we do want someone from the family to be around. The consent of this person is for surgical procedure under anaesthesia and not for the abortion itself*".

The providers also did not think the women themselves were particularly worried about either the consent insistence or privacy. They therefore made no special arrangement for maintaining privacy. As the medical officer at government tertiary care hospital put it, "*Privacy and confidentiality is not an issue with women. After all where can you get more anonymity than at a public hospital where thousands are milling around in the OPD? They are not hesitant to go to male gynaecologists either.*"

Alka Barua, AAP-I Qualitative Studies, 2003

water was a major problem and none of the interviewed women were satisfied with the cleanliness in the hospital. Similarly, women in Tamil Nadu (RUWSEC) also generally did not express any negative views about the services unless they had experienced post-abortion complications.

At the same time, there was some evidence that women's sense of dignity was compromised during their hospital stay. On initial questioning, the majority of the women in the Andhra study indicated that they were treated with dignity and respect. But on probing, more than half (15 out of 27) said that they did not feel they were treated with dignity and respect. The staff of the hospital scolded some of the poor women who did not have money. Most of them said that they went to the government hospital only because they could not afford to go anywhere else.

The length of the hospital stay for the client depended on the method that was used to perform the abortion and the period of gestation; typically, the longer the gestation period, the longer was the stay in the clinic. Both the government and the private sector in Andhra Pradesh and in Gujarat reported that at the time of discharge, they give or prescribe antibiotics to women for one week. Advice about the need for a follow-up visit, danger signals and the need for rest was also generally given. The women themselves were able to take little rest and care after the abortion. Factors such as poverty, housework and the need to work outside the home prevented them from taking rest after an abortion and forced them to resume their routine duties. Some women even indicated that abortion is not a major procedure (the way sterilisation is) requiring rest.

Overall, very few women in all the studies reported serious post-abortion morbidity. It is quite likely that the women tried to recall morbidity episodes during their lifetime and that immediate post-abortion illnesses tended to be forgotten because they were not life-threatening. However, the Andhra Pradesh study, which focused prospectively on this issue (and interviewed women immediately, two weeks, two months and six months, after the abortion), 21 of the 27 women reported morbidity such as excessive bleeding, weakness/nausea, abdominal pain or discomfort after abortion. While it is difficult to correlate this with medically significant morbidity, it does mean that women need care and support following an abortion. In the Andhra Pradesh study, most of the women who experienced morbidity sought medical care (18 out of 21), although this could well have been the result of the repeated contact with the interviewers who were themselves auxiliary nurse midwives. Morbidity was reported by 21 out of 34 women in the RUWSEC study, with the younger and older age groups almost equally represented. Excessive bleeding was the most commonly mentioned problem. The other problems were lower abdominal pain and back pain.

Provider Perspectives

Awareness about abortion laws

The studies that interviewed the providers indicated that formally trained providers were generally aware about the MTP Act, but not all para-functionaries such as ANMs were aware of it. At the same time, not all providers knew in detail the various situations in which the Act was applicable or in which abortion could or could not be performed. Even when the providers were aware that the consent of family members was not required, a majority of them in various regions insisted on it in order to protect themselves. In Andhra Pradesh, the providers said that they insist on obtaining husbands' authorisation to conduct abortion so that at a later stage the husbands cannot blame them. In urban Gujarat the consent was justified in terms of abortion being a surgical procedure done under anaesthesia, which requires consent. Women did not seem to mind if the providers insisted on the consent of husbands/family members because they generally do not go alone and some family member accompanies them.

The Gujarat sex-selective study indicated that the service providers who were interviewed were aware about the PNDT Act and its ramifications as well as about the consequences of aborting female foetuses. Ambivalence among the providers was evident in the two Gujarat studies. On the one hand, the providers indicated that the PNDT Act should be implemented with an iron rod and that violators should be punished. At the same time, evidently many of them conduct sex determination tests without much compunction and in violation of the Act, while denying that they perform sex-selective abortions. From the perspective of the clients the providers were by and large sympathetic to families that wanted to decide not only the family size but also the sex composition of their children.

Registration, certification and reporting

Registration is perceived as a long cumbersome procedure and the resultant formal reporting mechanisms is seen as a source of harassment as was revealed by Barua's study. As a result, qualified doctors who perform abortion shied away from registering as abortion providers—all the service providers interviewed in her study voiced apprehension about the procedure and legal formalities. Providers also admitted that they do not record or report all the abortions conducted by them. While the registered providers report a few cases, the unregistered providers do not maintain any records.

Perception of providers about abortion seekers

According to the providers, women who want to limit their family size in urban areas generally seek abortion in the first trimester and a majority of them come within eight weeks of pregnancy. Those who want to terminate the pregnancy for spacing take a little longer and seek abortion between 8–12 weeks. Providers also felt that some of the clients came to them after sex determination. But since the sex determination test and abortion can be obtained from different facilities, it was difficult for the providers to find out whether the woman coming for abortion of an 'unwanted' pregnancy had undergone a sex determination test elsewhere. Since they were essentially service providers, according to Barua, many of them in urban Gujarat preferred to maintain silence or presume that abortion is sought for termination of unwanted pregnancies and that they had a limited responsibility.

In Tamil Nadu, several providers mentioned that the stigma related to unmarried women seeking abortions is decreasing and many such women these days also access care early. Most of them reported having seen a steady increase in the number of unmarried clients over the years (Anandhi).

EMERGING CHALLENGES AND ADVOCACY

As highlighted before, findings and leads from small and disparate micro-studies cannot be generalised to represent the situation in the country as a whole. Such findings always need to be interpreted with caution and in context. Nevertheless, the qualitative studies undertaken to look into abortion issues, though small in scope and size, have thrown up some common patterns and themes.

Links between the unmet need for contraception and abortion

While, across the studies, women wanted to limit family size or space births, abortion often seemed to be a preferred alternative to the perceived side-effects and difficulties of obtaining and using temporary spacing methods. This was especially so in the two Tamil Nadu studies but similar reasons for not wanting to use spacing methods emerged from all the studies.

Son preference

Averting the birth of a female child or ensuring the birth of a male one, often under pressure from the conjugal and extended families, was reported as one of the reasons for abortion in most settings. While the use of 'modern' sex determination tests was more common in the western and northern parts of the country, the studies from the southern part of the country highlighted that women and communities use more traditional methods for predicting the sex of the foetus but with the same objective of averting female birth.

Preference for the private provider

Wherever private providers were available and women could afford abortion services from them, these seemed to be the preferred choice of women for reasons ranging from a perception that they were more qualified to the fact that the services were quick, there was less waiting time and the providers were better at maintaining confidentiality.

Needs of single, widowed or separated women

Although none of the studies was able to explore the context of unmarried adolescents, widowed or separated women in depth, studies across regions pointed to the fact that stigma is associated with pregnancies among these groups of women, the decision-making pattern is different, and family and community support is not always very forthcoming.

Several or all of the studies have also highlighted emerging areas of relevance for policy or programmatic action.

Addressing contraceptive needs

Since a majority of the women reported relying on abortion for limiting or spacing children, the unmet need for contraception among them needs to be addressed in family welfare programmes. There is a need not only for expanding the contraceptive choice but also for ensuring availability and informing women and men about the merits and limitations of various reversible methods of contraception. While it is heartening to note from the various studies that neither the public hospitals nor private providers any longer insist on or coerce clients to accept family planning after abortion, the providers cannot absolve themselves from promoting responsible family planning through appropriate counselling and by informing the clients about various methods of contraception.

Links between the PNDT Act and the MTP Act

Although the two legislations are independent of each other, the qualitative studies suggest that this distinction is hard to maintain in actual practice. The widespread campaign around the PNDT Act has led to high awareness about it among the communities however; knowledge of the legality of abortion services and the MTP Act still remains low. While abortion is a right of women in India and women can access it on economic or social grounds, there seems to be some evidence from these studies that women equate the ban on sex detection tests with 'killing of girls' and have also begun to interpret the PNDT Act to mean that all abortions (whether sex-selective or not) have now become illegal. Providers too often link the provisions of the two Acts. As the studies show, the commonest reason across the board for women to have an abortion is still linked to limiting and spacing their children (irrespective of sex composition), and unless a clear distinction can be maintained between these two issues and the reasons for the enactment of PNDT Act be made very clear, the effort to expand access to safe abortions itself will receive a setback in the coming years. Concerted efforts and sending out correct messages are very essential to clear the confusion.

Increasing awareness of the provisions of the MTP Act

Linked to the previous point, there is a clear need to expand awareness about when, where and under what circumstances legal abortion can be availed. This awareness needs to target not only women but also the gatekeepers of the decision-making process in the family. Women also need to know what are safe and quality services, and unless they know what their rights are, they will not be able to ask for information or question poor-quality care. Providers of services too need to know what the legal provisions are so that their own moral stands or their misperceptions about legal requirements (e.g., taking the signature of the husband) do not get in the way of providing services that are legal.

Role of medical technology

The qualitative studies complement the findings of the multicentric facility survey and highlight that outdated

methods of abortion like D&C continue to be used for reasons of familiarity and convenience, or lack of training in or misperceptions about safer options like vacuum aspiration. The recent legalisation of Mifepristone in the country provides yet another option of a safe and effective technology that can increase access and expand choice. Since the legalisation of this technology happened after these studies were designed, none of them explored the implications of this new technology in a systematic way. The little information that did emerge points to the fact that it appears to be used by some practitioners and is preferred by some clients. The Ahmedabad study suggested that in some settings it might also be available directly to women over the counter (as indeed are most drugs in the country). All these issues require further exploration. The technology is known to be safe and effective and we need to understand how best to exploit its full potential in promoting safe abortions, while at the same time guarding against misuse that can stem from misinformation.

Quality of care

While life-threatening morbidity from abortions did not emerge as a major issue of concern, women's experiences at health facilities as well as the assessment of the providers themselves show that the quality of care, especially of counselling, is a neglected area. Public sector facilities appear to have high case loads and in adequate time to devote to pre- or post- procedure counselling; private sector providers appear not to see the necessity of counselling. In public facilities women often experienced judgmental attitudes and rude behaviour from the providers. All types of providers could benefit from gender sensitivity training, non-judgmental attitudes and value clarification, and all programmes should focus on putting the women and their individual needs as the focal point around which services must revolve.

The entire process of the qualitative studies also showed that partnerships between diverse groups of people drawn from different disciplines and with differing ideologies and positions are possible and productive. The collective process of integrating diverse viewpoints enhances a common understanding of the issue of unsafe abortions, and, in the long run, is an essential step in progressing towards the common goal of making abortion an infrequently used but safe alternative for women faced with unwanted pregnancies.

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NOTES

1 The overview is a synthesis of the findings of eight qualitative studies undertaken by partners whose names and affiliated organisations, and the titles of the studies are shown in tabular form on page 5 of this report. Without their seminal contribu-

tion to the issues and discussion this overview would not have been possible. We thank each and every one of them for the hard work that they have put in and their commitment to the cause of abortion as a woman's right. We extend many thanks to Manisha Chaudhry for her excellent editorial inputs.

2 The HealthWatch network has drawn individuals from diverse backgrounds ranging from workers of grassroots organisations, feminists, academicians, researchers and activists.

3 The research studies undertaken in nine settings were brought out as a HealthWatch publication, titled *The Community Needs-Based Reproductive and Child Health in India: Progress and Constraints*, HealthWatch Trust, Jaipur, 1999.

4 Ms. Ravindran, with nearly two decades of experience with a women's organisation in Tamil Nadu called RUWSEC, has worked extensively on women's health issues.

5 Members of the Project Advisory Committee for Qualitative Studies included: Gita Sen (IIM, Bangalore), Lakshmi Lingam (TISS, Mumbai), Manisha Gupte (Masum, Pune), Sundari Ravindran (RUWSEC, Chengalpattu, Tamil Nadu), Ena Singh (New Delhi), Leela Visaria (HealthWatch), Ravi Duggal (CEHAT, Mumbai and Joint Coordinator AAP–I) and Vimala Ramachandran (Educational Resource Unit, New Delhi and Joint Coordinator, AAP–I). The Member Secretary of this Committee was Shveta Kalyanwala, Programme Officer, HealthWatch.

6 After the methodology workshop, two of the ten proposals were not considered for funding due to various reasons, and so eight qualitative studies were commissioned.

7 The contribution of the researchers and paper reviewers is gratefully acknowledged. Those who participated in the meeting were: R.N. Gupta, Sudarshan Iyengar, Shyam Astekar, Padmini Swaminathan, Syeed Unissah, Dinesh Agarwal, Alka Barua, Sharad Iyengar, Wajahat Ullah Khan, Alex George, Sandhya Barge, Kirti Iyengar, M. Prakasamma, S.K. Misra, Sudha Tiwari, Anjali Radkar, S.N. Morankar, S. Anandhi, Balasubramanian, Geeta Sodhi, K. Nagaraj and Ravi Duggal.

8 Please note that each of the eight studies explored some or all of these issues to varying degrees based on the focus of the study.

9 The RUWSEC study was carried out in an area where the organisational activities have focused on increasing the awareness and use of spacing methods. Condoms are promoted in the community and also among men. The methods are also available at their clinics free of cost. The study findings on contraception—in this scenario—show how difficult it is to increase the acceptance of reversible spacing methods.

10 Radkar's sample consisted of all women of ages 15–49 who reported an induced abortion in the two study villages where the study was conducted. Barua's sample of 62 women was a purposively selected sample of women who had an induced abortion. The two figures therefore do not indicate the extent of sex-selective abortion in the states and should not be compared.

11 This is not unique to Tamil Nadu or to the study villages. There are studies which refer to this phenomenon for seeking of abortion. For instance, see Ganatra (2000: 201).

12 This term has been borrowed from an Egyptian study of women's reproductive lives. It is a useful analytical tool to understand how unmarried girls who work in the companies comply with the discriminatory and sexually exploitative work culture against their own wishes, for the sake of deriving some strategic benefits like income and freedom and mobility. At the same time, they constantly complain and regret the situation they are in. Here, we can see 'accommodation' interacting with 'resistance'. For a detailed discussion on 'strategic accommodation', see Dawala et al. (2001).

13 Although in the research reported here informal providers of abortion were rarely mentioned by the study participants, HealthWatch in association with Ipas, India, conducted a multicentric study of informal providers in six parts of the country where, except for one centre, women did seek the services of informal providers in certain situations.

Availability and Accessibility of Abortion Care

Ahmedabad's Urban Slums

ALKA BARUA

INTRODUCTION

The World Health Organisation (WHO) estimates that, of the 20 million unsafe abortions that take place each year, nearly 90 per cent are in the developing world, and of these almost one-third occur in southern Asia alone. According to the Government of India's Family Planning Yearbook, 4,65,705 pregnancies were medically terminated in India during 1996–97. These, however, were recorded or legal abortions. It is estimated that abortions several times this number are performed outside the legal system, often by unskilled providers, and are deemed unsafe.

In India, the Medical Termination of Pregnancy (MTP) Act of 1971 allows legal termination of pregnancies to women over 18 years of age—irrespective of marital status—as a health measure, as a humanitarian measure in cases of sex crimes, as a eugenic measure and in the event of contraception failure. Abortions induced for these *specified reasons* and *conducted by recognised/registered service providers and centres* that meet the stringent criteria under the Act are deemed legal (Chhabra and Nuna 1993).

While the cumbersome recognition process under the Act is a major bottleneck in the provision of recognised or legal services, the skewed distribution of recognised centres also serves to keep such services beyond the reach of women who seek them. This, perhaps, is one reason for the large number of illegal abortions. Even where available, recognised services are frequently not used. The extent of this low usage has been estimated and quoted in several studies and write-ups. In urban areas, where physical accessibility to legal services is not an issue, factors such as the attitude of health care providers and the degree of privacy and confidentiality available (Cehat 2001) are known to inhibit recourse to safe legal abortion. On the other hand, a large proportion of women undergo abortion for regulating family size, which, as per the MTP Act, is illegal. Under these circumstances, women access any available centre that provides the services, even if it is illegal or unrecognised (Shelley et al. 2001). Reasons for low utilisation of approved legal services are multiple, and span the entire range from women seekers to service providers and their facilities. Thus the Act, though liberal, has not translated into availability of safe legal services for pregnant women who seek abortions (Cehat 2001).

Women's organisations and critics of the Act argue that in a country like India, where national programmes covertly and openly encourage smaller families, exploitation of the Act for demographic purposes is inevitable (Gupte et al. 1997: 77–86). Statistics indicate that the services are used primarily for spacing, control of family size and for having a child of the desired sex. This is despite the fact that the committee which was respon-

sible for the genesis of the Act had emphasised that '*legalising abortions with a view of obtaining demographic results is impractical and may even defeat the constructive and positive practice of family planning through contraception*' (Ministry of Health 1996: 47, cited in Centre for Operations Research and Training 1996).

In implementation, therefore, there appears to be a significant gap between the intent and the ground reality. The purpose of passing the Act was to ensure women safe, legal medical services for pregnancy termination when required. The ground reality indicates that for making good quality services available to women, the social and cultural context of utilisation as well as provision of services should form the cornerstone of the implementation process. To increase the accessibility of services and to make them socially appropriate and acceptable, it is critical to take into account both the women's perspective in seeking services from various providers—what are their expectations? how do they want the services to be delivered?—as well as the providers' viewpoint. What are providers' perceptions of these services and how they should be delivered? What are their views on the MTP Act and the process of licensing?

OBJECTIVES OF THE STUDY

To understand these two sets of perspectives, the Foundation for Research in Health Systems (FRHS) undertook a study of selected abortion care providers and seekers in two urban slums of Ahmedabad city in the state of Gujarat. The objective of this effort was:

1. To understand the nature, distribution and quality of abortion services accessed, and the characteristics of and reasons for women seeking abortion services from approved or unlicensed and unqualified providers.
2. To study the views of users and providers on abortion-related morbidity and mortality.

The rationale for focusing on providers and seekers of abortion from the same area was that since very little information is available about the providers' perspectives and their views on the problems and complications arising out of abortions, and not much is known about factors that influence the seekers' decision-making about abortion, eliciting the perspectives of seekers and providers in the same locality would help in designing interventions that could improve the quality of abortion care.

REVIEW OF AVAILABLE LITERATURE

Before undertaking the research, the available literature was reviewed to understand the existing situation with regard to abortion seekers, abortion services available, their use and the factors that affect it.

Women are known to seek abortions for a variety of reasons, depending on age group and marital status. While the reasons for abortion among unmarried girls and widows are obvious, adolescent married girls in rural Maharashtra chose abortion as their previous child was still too young, and older women because they did not want any more children (Ganatra and Hirve 2002: 76–85).

The practice of aborting unwanted pregnancies is widespread. In Patna, Bhubaneswar and Baroda, 67 per cent of the women who underwent abortions had achieved their desired family size and did not want additional children (Centre for Operations Research and Training 1996). About 27 per cent reported that their last child was too young, and among them, 17 per cent wanted to space the next childbirth (Khan, Patel and Chandrashekhar 1990: 70–85).

Another reason, which earlier used to be covert but is now very visible, is the desire to get rid of the female foetus. The sex ratio in Gujarat for girls in the 0–6 age group has fallen to 878 from 928 per 1000 boys (Government of India 2001). What is alarming is that in progressive states like Maharashtra, one in six married women with a history of induced abortion in the previous eighteen months had no hesitation in reporting that abortion had been subsequent to a sex determination test showing a female foetus (Ganatra and Hirve 2002: 76–86). Can we attribute this state of affairs merely to poor implementation of the MTP Act, lethargy on the part of the medical community to comply with legislative measures and medical ethics, unawareness of the Act, or to the socio-cultural milieu (Cehat 2001)?

The MTP Act does not permit induced abortions on demand. In its much-debated paragraph 8.25, the document on the ICPD's (International Conference on Population Development) Programme of Action (ICPD 1994) states: '*In no case should abortion be promoted as a method of family planning.*' But a large proportion of women are known to undergo abortion for regulating family size as they are unaware of the conditions stipulated under the MTP Act (Ganatra and Hirve 2002: 76–85). The onus of judging the necessity for abortion

rests with the medical practitioner, whose opinion is taken in good faith to reflect valid, legal indication. But there is little regulation and it is known that many practitioners regard all kinds of conditions as eligible for abortion, depending more on their personal beliefs than on stipulations of the law (*Manushi* 2002).

A study conducted in an urban hospital in Maharashtra revealed that the majority of the 195 women (84 per cent) who were part of the sample assumed that induced abortion is illegal in India, but more than half the women (56 per cent) also said that if need be they would go ahead and have an abortion regardless of whether or not it is legal (Shelley et al. 2001). This flouting of legal requirements is clearly reflected in women seeking abortions after sex determination, though awareness about its illegality is almost universal. Women and their partners seem not to be unduly concerned about the legal indications for abortion specified under the Act, as, in their view, termination of an 'unwanted' pregnancy is their right.

In the same study, 14 per cent of the wives, 18 per cent of their husbands and 29 per cent of married men felt that women should be able to have an abortion if the foetus is female (ibid.). What is disturbing is that about 90 per cent of the same men and their wives knew where to go for a sex determination test (ibid.). The significance of this needs to be underscored, as men take the decision for abortion either alone or jointly with their wives.

This was borne out by another study in urban Maharashtra where, while all couples reported having discussed the issue, the husband's consent was a major factor in the decision. Out of the 170 unwanted pregnancies, 34 of the 49 women who wanted an abortion had to first take their husbands' consent (ibid.). Though not much information is available on the exact process of decision-making, women's lack of autonomy in making decisions relating to abortions seems to be more pronounced in the case of abortions after sex determination as compared to abortions for other reasons (Ganatra and Hirve 2002: 76–85).

The process of decision-making takes its own time and course. A study spanning six years of obstetric admissions in a hospital in Maharashtra reflected delay in accessing abortion because of this process. Of the 17 per cent admissions for abortions, 59 per cent were in the first trimester of pregnancy and 41 per cent in the second trimester (Solapurkar et al. 1985: 46–52). The delay was particularly evident among adolescent married girls, who are more likely to have second trimester abortions.

The reason for the decision determines the gestation period at which the pregnancy is terminated. For example, sex determination by amniocentesis is done after eighteen weeks, by ultrasound after thirteen weeks and by *Chorionic Villi* sampling at around six to seven weeks. Of these, ultrasound is the most often used method for sex determination in rural areas. It is therefore not surprising that half the women in rural Maharashtra who go in for abortion after twelve weeks of pregnancy do so after sex determination.

The decision-making process determines not only when but also where abortions are sought. Earlier, women resorted to home remedies and the services of quacks. Recent studies have shown that illiterate women (Varkey et al. 2000), women who do not have their husbands' support, or married adolescent girls who lack mobility and control over resources are more likely to use untrained and inexpensive health providers (Ganatra and Hirve 2002: 76–85). The rest go to qualified providers. However, not all these providers are recognised under the MTP Act and therefore the abortions performed by them are not 'legal'.

The explanations for this are many. For instance, government sector statistics on abortion in Gujarat show that MTP cases are either stagnant or are decreasing in spite of the increase in the number of registered MTP facilities. According to one study, only about 53 per cent of primary health centres (PHCs) and community health centres (CHCs) registered for providing abortion services in the state were actually offering the services. About 70–92 per cent of the facilities were not providing services because of lack of trained doctors, and 14–31 per cent because of non-availability of required equipment (Khan et al. 1994).

Conversely, there are facilities that provide abortion services though they are not approved or registered. In nine *tehsils* of Maharashtra, for every registered abortion care facility (ACF), there were around three non-registered ACFs. Of the total, 56 per cent were not qualified under the MTP Act and only about 8 per cent of the qualified abortion providers were based in public health care facilities (Bandewar 2000: 39–43).

Qualification or registration under the MTP Act is a major obstacle in the provision of recognised services. The certification process requires installation of

equipment and supplies for general anaesthesia and abdominal surgery, a guarantee that a trained provider and anaesthetist are available, site inspection and sequential recommendations by district and state health authorities (Iyengar and Iyengar 2002: 54–63).

Providers in rural areas who do only early abortions using vacuum aspiration (ibid.) perceive the clause relating to general anaesthesia and major surgical equipment as unwarranted, expensive and difficult to arrange. The Act exclusively addresses hospital-based provision of induced abortions and the emergence of medical methods (Population Council 1998: 257–59) makes these requirements appear excessive (Iyengar and Iyengar 2002: 54–63). The insistence by the Ministry of Health (MOH) and the Family Welfare Department (FW) on the purchase of equipment with the Indian Standards Institute (ISI) mark, produced by only one company in the country, makes it difficult for the demand to be met (Khan et al. 1994).

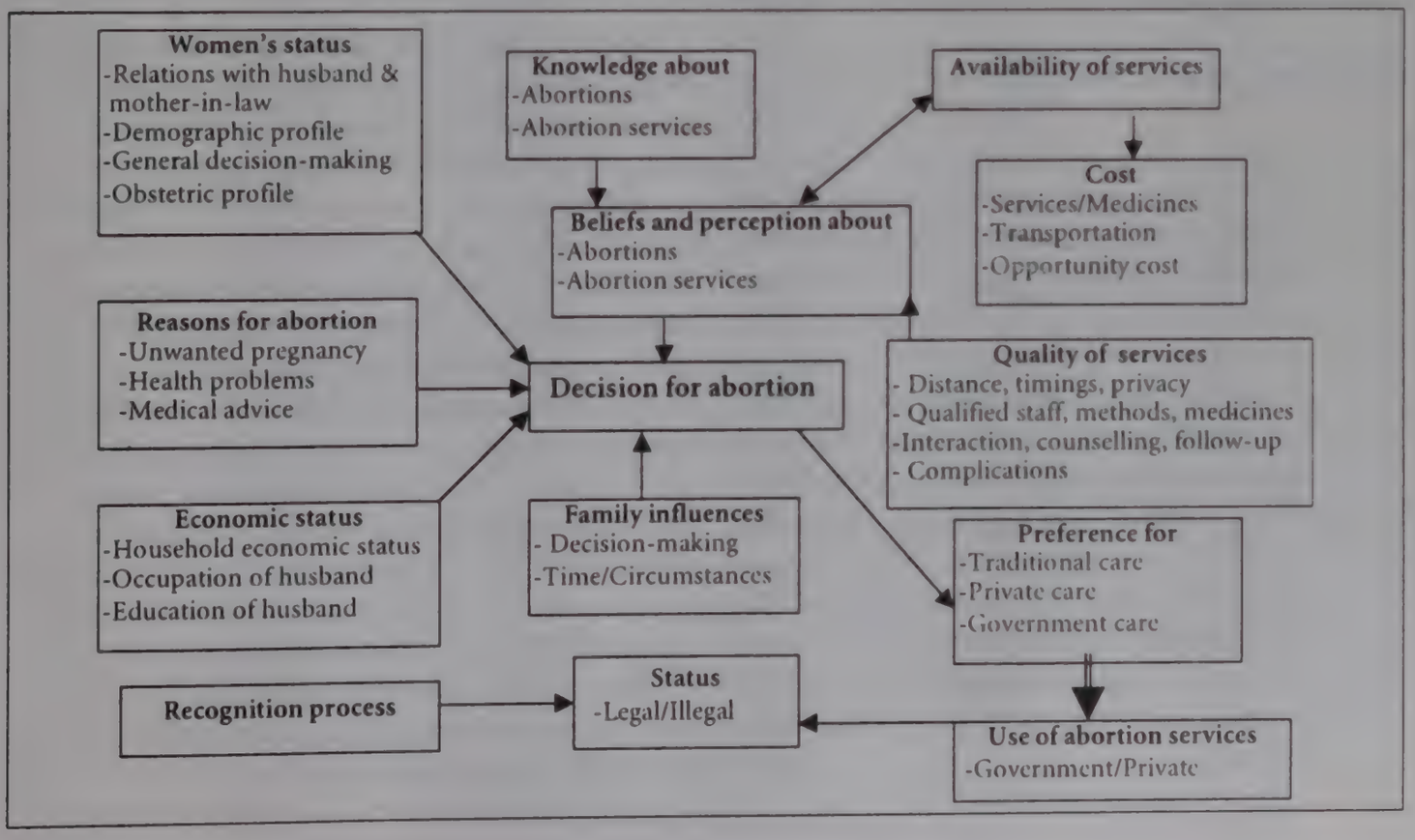
The other problem is the stringent training criteria. Most training centres find the prescribed norm of fifteen days of on-the-job training and practical experience of conducting at least twenty-five abortions impossible to meet. Further, in most states, only teaching hospitals carry out MTP training and their courses are not accessible to doctors in private service. This limits the number of legal abortion providers (Iyengar and Iyengar 2001: 54–63).

The registration process itself is fraught with problems and mired in red tape. In Rajasthan, a doctor's application was returned twice for re-submission with additional documents which had not been listed in the application guide (ibid.). A survey of its members by the Federation of Obstetrician and Gynaecologist Society of India (FOGSI) revealed that while 29 per cent of the centres did not have any problems, 13 per cent experienced delays ranging from one to seven years, 44 per cent had difficulties in navigating the recognition process, and 12 per cent were unaware of the need for obtaining recognition. Many FOGSI members applied for registration, but because of delays in approval they continued to perform technically illegal services albeit under safe and hygienic conditions (Sheriar Committee 2001).

CONCEPTUAL FRAMEWORK

Based on the scenario emerging from our literature review, we developed a conceptual framework for the study indicating the critical items to be studied, such as the

Health-seeking Behaviour for Abortion



key factors, the variables and their presumed relationships. However, in the light of the new data coming in, we felt it was necessary to make a few revisions in order to make the framework more precise, to replace empirically obscure boxes with more meaningful ones and to reconstruct the relationship between the key factors. The graphic illustration given below depicts the framework.

Data was collected on various key factors and variables that were relevant in the context of our conceptual framework. Additional background information on women as well as service providers was collected wherever deemed necessary to get a holistic picture of the dynamics involved in accessing abortion services. For example, providers' views were sought on a range of topics such as prevalence and frequency of induced abortions, profile of women seekers, reasons for induced abortions, process of decision-making, steps taken by women before actual use, pre-abortion services offered at the facility, methods of abortion, cost, stay, post-abortion counselling, care, follow-up, experiences with use/provision of services, legality of abortion and the MTP Act.

A preliminary list of research questions based on the framework was made with the objective of making the theoretical assumptions more explicit. The main aim, however, was to come up with the methodology to be adopted and to make the data collection more focused.

METHODOLOGY

Location

Ahmedabad is the second largest city in western India with a population of about 42 lakh, according to the 2001 Census of India. About 40 per cent of this population is located in slums. The population has a sex ratio of 889 and a literacy rate of 67 per cent. Health facilities for the city slums are provided by a network of government and municipal tertiary care hospitals, municipal clinics, maternity homes and urban family welfare centres (UFWCs), as well as by private doctors. There are about 37 UFWCs, including five post-partum units.

Based on the assumption that accessibility to providers would be comparatively easier for the more affluent classes as they could afford to spend more time and money for their needs, FRHS decided to do the study in two urban slums.

SLUM–1

This slum is a ward within Ahmedabad municipal limits and, being very close to the city centre, enjoys very good connectivity with the rest of the city. It has all the basic amenities provided by the city municipal corporation. It has a population of about 70,000, comprising mainly Patels, Thakores and Rajputs. The socio-economic condition of the residents is better than of those in SLUM–2 and the houses are largely *pucca*.

Table 1: Slums' Characteristics

Indicator	*Area*	
	SLUM–1	*SLUM–2*
Location	Close to city centre	Outskirts
In corporation limits	Yes	No
Population	70,000	40,000
Predominant population	Patels, Thakores Rajputs	Migrant tribals
Civic amenities	Available	Not available
Abortion services	*Dais*	*Dais*
	Gen. practitioners	Gen. practitioners
	Pvt. gynaecologists	Pvt. gynaecologists
	National NGO	
	Local NGO	
	CFPC	
	Tertiary care hosp.	

Health facilities are available in the form of a large tertiary care municipal hospital, a national level non-government service facility which is also an approved abortion service centre, several private practitioners including *dais* and a Comprehensive Family Planning Centre (CFPC) run by a non-government organisation. The tertiary care hospital is a typical full-fledged, well-equipped, multi-speciality service facility. The national NGO has facilities mainly for provision of antenatal, family planning, menstrual regulation, MTP, tubectomy and laparoscopy services, but does not have any outreach services. The CFPC provides basic curative and preventive services mainly through its outpatients department (OPD), as well as outreach services through its cadre of female health workers. In addition, the doctors staffing the OPD refer cases for any surgical intervention, mainly tubectomy and MTP, either to the tertiary care hospital, the national-level NGO or private gynaecologists' maternity homes.

SLUM–2

This slum is on the outskirts of the city and has a population of about 40,000. It is inhabited mainly by migrants from a tribal community of Udaipur district in the neighbouring state of Rajasthan. The houses in this slum are mostly *kachcha*/semi-*pucca*. As the slum is outside the corporation limits, it does not have the amenities usually provided by the municipal corporation, but it does have a local panchayat that supplies water in some areas and runs a clinic along the lines of a PHC.

At the time of the study it had poor health facilities. It had neither a tertiary care hospital, nor a national or local NGO-run service facility. However, it did have clinics owned by two private gynaecologists in its close vicinity.

DATA COLLECTION

Methods

Since the objectives of the research study were to understand the perspectives of abortion service users as well as providers, and the effect of these along with the family dynamics of the users on their use of abortion services, we decided to use a qualitative methodology. The methods adopted therefore comprised in-depth interviews and focus group discussions (FGDs). However, flexibility about the order in which to use the two techniques was deliberately retained as the topic is sensitive. It was felt that women might not be very forthcoming in a group discussion in the early stages of the study. Also, since individual perceptions, knowledge and practices relating to abortion service use were equally a part of our focus, we felt that interviews offered the possibility of studying these in greater detail. We therefore began the research with in-depth interviews. Once the investigators developed a rapport with women in the community, FGDs were done for triangulation of findings of the interviews, as well as to determine the general trend of perceptions and practices.

Sample

In-depth interviews

In-depth interviews were held with abortion service providers as well as women users in the two slums. Since this was a qualitative study looking at the perspectives of seekers as well as providers, and not an attempt to study prevalence, morbidity and mortality rates, the sample was purposive. The plan was to cover 18 providers (including unqualified providers) and 60 women seekers of abortion in the study.

Since the sample of providers was based on the reporting by women, and since they did not report any unqualified providers, in the end we interviewed two gynaecologists from the tertiary care hospital, a medical officer each from the national and local-level NGO, two private gynaecologists, one qualified general practitioner and two nurses in SLUM–1, and two private gynaecologists, one qualified general practitioner and two *dais* in SLUM–2.

The 60 women, 30 from each slum, were selected based on their having availed of abortion services in the two years prior to the study.

Focus group discussions

FGDs were planned with the NGO staff, key informants and community women in the reproductive age group.

Instruments

Loose, semi-structured interview field guides were designed for in-depth interviews with women and abortion care providers. Guides were also developed for FGDs. The field guides were formulated based on the research questions developed from our conceptual framework, and were finalised after pre-testing and getting a feedback from our investigators and consultants. Though we were not working with a well-delineated construct, we preferred to leave the interview guides semi-structured as we felt that this would provide clarity and focus to the study.

Forms for the verbal consent of respondents were also developed. After approval by FRHS's in-house ethical committee, the instruments and consent form were sent to HealthWatch, New Delhi, for comments.

Process

In-depth interviews

We took the help of key informants or women who had availed of abortion services in the past two years to identify the providers and to then interview a representative sample. However, during the course of the study, we found that none of the women in either slum had listed any unqualified provider. Therefore, unqualified providers were dropped from the sample and a larger number of private providers were interviewed, since their services were reported to be more frequently used. Similarly, though the government tertiary hospital is not

located in either of the slums, women did report using the services there. We therefore decided to include a medical officer from that hospital in our sample.

Access to health providers was not a problem at all. They were quite forthcoming in talking about their understanding of the stipulations contained in the MTP Act and its actual implementation. And though the research team insisted on taking their consent and informing them about keeping their identity confidential, they, particularly the one from the government hospital, did not seem to be very concerned about it. They were very frank in their views, even when these conflicted with the stipulations of the Act.

We asked the key informants to help us identify women who had availed of abortion services in the past two years. However, we deliberately excluded service providers from our group of key informants, as the ethics of medical practice do not allow revelation of specific services used by clients. We also used the snowballing technique to identify women for interviews. Access to women was not a problem in SLUM–2 as the women in this area, mainly from migrant families of Rajasthan, looked forward to any initiative which they thought might, at a later date, help them with their problems. They readily gave their consent. They were given no incentives or promises by the investigators to get their cooperation nor was any statement made to get their hopes up. Their response remained good till the end of the study.

Both the women users and providers were interviewed at a time and place specified by them. In cases where information on all our questions was not forthcoming in one sitting, the interviews were conducted in more than one sitting. However, this was rarely necessary. As far as possible, the interviews were completed in one sitting as the respondents found repeated contacts inconvenient and were unwilling to give more days for the interviews.

Focus group discussions

Their heterogeneity and the fact that there were very few of them meant that we could not conduct FGDs with NGO staff or key informants. In the end, we conducted FGDs with two groups of community women in the reproductive age group from each of the slums. The discussions covered our research questions as well as the local terminology for abortion (both spontaneous and induced), and the methods used for induced abortions.

Recruitment and Training of Research Team

The four investigators we selected for the study were between 22 and 24 years of age. They were all graduates with some research experience, belonged to the city and could speak the local language. Before commencing the study, we invited experts to provide them with intense training in our research methodology and information on technical details relating to abortion.

Training sessions for the investigators and supervisors were held in January 2002 and included information on conception, abortions, the MTP Act, sex determination, communicative skills and vocabulary listing. The interviewers were also given training in the field.

Fieldwork

The fieldwork started in the second week of February 2002 but came to a standstill within a week because of communal unrest in the city, and could be resumed only at the end of June 2002. The time schedule for fieldwork was such that the investigators conducted interviews four days in the week and met with the two supervisors and co-investigators twice a week. The detailed notes they prepared helped us to continuously assess the fieldwork as well as make modifications in the guides as and when the need arose. The investigators were given the freedom to make on-the-spot decisions and minor modifications in the guides and flow of questions when faced with any unanticipated problem. The fieldwork was finished in October 2002.

By the end of the study, 18 service providers (not including unqualified providers) and 62 women (30 and 32 from each slum) had been interviewed. Interviews with two women had to be discarded as their history of abortion was not very clear despite repeated checks.

Data Entry and Analysis

All the interviews were transcribed in the local language and then translated into English. The responses in the FGDs were noted down and converted into a single, coherent description of the discussions. The data were analysed both manually and by using Atlas-ti.

Field Problems and Modifications in Methodology

Since we had kept our methodology flexible, it was easy to adapt to difficulties arising in the field without compromising on the larger design and objectives of the study. For instance:

- There were problems when the fieldwork started because of communal tension in the city. This resulted in having to replace one of the selected slums with another having similar characteristics.
- We had decided to include in our study sample only women who had accessed abortion services in the last two years before commencement of the study. However, due to curtailment of the study period and with a view to covering the sample agreed upon, it was decided to increase the reference period to five years.
- Unqualified providers had to be dropped from the sample as not a single one was reported to have been accessed by the women interviewed. Similarly, general practitioners, nurses and *dais* were included only as referral service providers since that was their reported role.
- FGDs were planned with the staff of the NGO providing/facilitating these services, as well as with key informants. But the NGO working in the area did not have enough workers of the same cadre to make an FGD worthwhile. The number of key informants was also too small to conduct an FGD.

Access to women was a little difficult in SLUM–1. The women here were a little more circumspect and did not open up to the interviewers very easily. To get around this problem, we took the help of the local NGO which has been running a clinic in the area for the last two decades. Its fieldworkers accompanied the investigators and introduced them to the women, and this greatly eased our entry into the community. After that, most women in this area had no hesitation about confessing that they had undergone abortion and that too after sex determination, even though they were aware that it was against the law!

Although not a single woman in either area refused to be interviewed, within the first couple of days itself the investigators realised that it might not be possible to arrange a second interview with the same woman. They therefore conducted the interviews in teams of two, and as far as possible elicited all the required information in one sitting.

Except for one health provider in SLUM–1 who stubbornly refused to give an interview, all the providers were happy to meet with the investigators. Access to the medical officer from the municipal tertiary care hospital followed a very strict protocol and it took the research team two months to get clearance from the superintendent of the hospital.

Steps Taken to Ensure Ethical Standards

Research on sensitive subjects usually requires the interviewer to obtain the written consent of respondents and to express a guarantee of confidentiality. However, in our experience, any mention of written consent becomes a major obstacle since women are generally not prepared to sign any written statement. But as long as they know the purpose of the study and are certain that their identities will remain confidential, they are quite prepared to give their oral consent. This is precisely the strategy we adopted for our study. Informants were given detailed information about what the study was meant to achieve. They were also given the option of not participating or even quitting midway if that was what they wanted. At the same time it was made clear to them that no specific benefit would accrue if they decided to participate in the study. Confidentiality of the data collected and anonymity of the respondents were assured and data was collected only with their informed consent.

Service providers, both registered and non-registered, were not used at any stage as key informants to identify abortion seekers, keeping in view the ethics of medical practice. Confidentiality of information relating to service provision obtained from them was strictly maintained.

Though key informants did list a few unmarried and single women who had opted to abort unwanted pregnancy, they were not included in the study. It is important for such women to keep their abortion a secret, and we did want to draw attention to them by actively seeking them out for an interview. Similarly, the research team was concerned about compromising the confidentiality of married women who had undergone abortion without the family's knowledge. However, the team did not come across a single case of abortion that was done without some family support.

The following sections of our report describe the findings from the in-depth interviews with 62 women reporting abortions in five years prior to the study and 18 service providers, as well as the FGDs conducted with two groups of women from both sites. The names of the respondents have been changed to maintain anonymity.

FINDINGS: PART I

Profile of Women in the Sample

A total of 62 women—30 from SLUM–1 and 32 from SLUM–2—were interviewed. More than half the interviewed women were in the 25–30 age group. Only about a third of them had got married after the legal age of marriage, i.e. 18 years. More than half the women in the sample were literate. Twenty-three women (more than one-third) reported three or more living children. Only six women reported having no living child. In all, the women reported 92 induced and five spontaneous abortions.

Table 2: Characteristics of Women in the Sample

Indicator		*Number*
	N	62
Current age	<=20	6
	21–24	10
	25–30	35
	31–34	8
	35+	3
Age at marriage	<18	40
	>=18	22
Education	Illiterate	28
	Literate	34
Living children	0	6
	1	8
	2	25
	3+	23
Abortions	1	42
	2	13
	3+	8

While this was the overall picture, the women in SLUM–2 differed from those selected in SLUM–1 in terms of certain characteristics. The women in SLUM–2 were comparatively younger and the majority of them, i.e. eight out of ten, had married before completing 18 years. More women (about two-thirds) in SLUM–2 were illiterate, but they had some form of employment.

> We are Thakores and are worshippers of Lord Krishna and Chamundadevi. I was never sent to school and was married when I was 14. In our community girls get married very early. My husband often beats me, so I left him a couple of months ago and came to live at my father's house. I myself work as a domestic servant and earn Rs 600 per month. (Santoshi, 25-year-old illiterate woman from SLUM–2)

All the six women who reported no living children belonged to this slum.

> I have no children though I have been pregnant twice. First time the doctor said that '*kothli bahu garam chhe*' (uterus is 'hot' and not conducive to foetal growth). I tried 'cooling' home remedies . . . but after some time the doctor advised abortion as the baby was not growing. I had an abortion at the doctor's own hospital. (Rama, 17-year-old illiterate woman from SLUM–2)

Women from the sample in SLUM–1, on the other hand, reported at least one living child. This slum also reported a larger number of abortions and more repeated abortions.

Of the 92 abortions reported, 30 women in SLUM–1 accounted for 50 (1.67 abortions per woman) and 32 women in SLUM–2 were responsible for 42 (1.31 abortions per woman). Further, in SLUM–1 more women reported undergoing repeated abortions.

> A year-and-a-half after I delivered my first daughter by an operation, I became pregnant again. I went for sonography with my *jethani* (sister-in-law) as I did not want another daughter. It was a female foetus so my husband and I decided to get an abortion done. Within a year I was pregnant again . . . I was with my parents at Rajkot. . . . I again got a sonography done and then had an abortion as it was a girl. Within a year I missed my periods for the fourth time. I went back to Rajkot and consulted the same doctor. Again after sonography I had an abortion. Now I want to go for operation but my *jethani* is not allowing me as I don't have a son. (Bhavini, 28-year-old literate girl from SLUM–1)

Women's Perspective

Though 92 abortions were reported, the information pertaining to service use presented here covers only 62, i.e. the latest abortion per woman in the five-year reference period before the study.

Reasons for induced abortions

More than half of the total abortions (34) in the last five years were reportedly for limiting family size or spacing children.

College-educated, 30-year-old Jaya from SLUM–1 said:

I already had two children and was on Mala D. Once or twice I forgot to take them and I missed my periods. I realised that I must be pregnant and went with my *nanand* (husband's younger sister) to Dr Mehta's hospital for an abortion. . .

Eighteen abortions were consequent to medical advice. These were more common in SLUM–2, which reported as many as 15 of these. All abortions based on medical advice were reportedly due to health problems of the woman or the foetus.

Jiyaben, an illiterate daily wage labourer from SLUM–2, said:

In the beginning of the fifth month, when I was in the toilet, I had a suffocating sensation and felt as if something fell down from my body. I then started bleeding. My mother and brother immediately took me to a private doctor in an autorickshaw. The doctor examined me and said that perhaps I had started losing the baby and advised '*andar saaf-sufi karvi padshe*' (inside of the uterus needs to be cleaned). My relatives agreed and I had to get the abortion done.

Since almost all these pregnancies were 'wanted', the women consulted a gynaecologist and made all attempts to salvage the pregnancy before getting it terminated. Some women also reported being unconvinced by the doctor's advice to terminate for medical reasons and seeking a second opinion:

The doctor said that my '*kothli bahu garm che*' and the baby cannot survive in such a *kothli*. I was advised abortion. Three months after the abortion, I became pregnant again. This time the doctor scolded me for getting pregnant so soon. She gave me 12 tablets saying, '*kothli nabli che*'(uterus is weak). Each tablet cost Rs 100. . . . My family decided to take a second opinion. My mother-in-law said, '*Balak naa rahe pun dar vakhate naa rahe evu thodi bane? Mate aapne bije tapas kariye*' (A woman may have miscarriage but it is not a rule that each pregnancy is miscarried. We should consult another doctor). The second doctor said that there was nothing wrong with the pregnancy and the baby would survive! (Darshini, 23 years, SSC pass, from SLUM–2).

Ten of the abortions were after sex determination and confirmation of female foetus. More of them were reported from SLUM–1 (8 out of 10) than SLUM–2. These abortions were usually conducted after a sonography, generally around 12–16 weeks of pregnancy. A few were performed even after 16 weeks and the women did not see anything wrong with this.

Deepika, a woman from SLUM–1, said:

I became pregnant for the second time when my daughter was one-and-a-half years old. I went to a private doctor after the third month for a sex test as I knew that that is when it is done. The doctor did a sonography and said it was a girl. But he did not write this down as it is illegal. My husband and I did not want another girl and decided on abortion. I had my abortion at the same clinic.

There were some rare cases where the reason for abortion was cited as 'family dispute' or a way to teach an 'erring' husband or the husband's family a lesson. As one of them mentioned:

My mother-in-law and husband have been harassing and beating me since my marriage. Once, when I was about four months pregnant, my husband, who was drunk at the time, beat me up. There and then I decided to abort the baby. The doctor did a sonography on his own and said that it was a male foetus and maybe I would like to continue with the pregnancy. But I was very clear in my mind. I got the abortion done without letting anybody know except my close friend.

Table 3: Reasons for Induced Abortions

Indicator		*Total Women*
		N= 62
Reasons	Family planning	34
	Health problems	18
	Sex determination	10

Decision-making for induced abortions

Seventeen women whose pregnancies were terminated on medical advice said that the decision had been made by the doctor. About a fourth of the women in the sample reported that the decision for abortion was made either by the family members or the couples themselves. A fifth (12) said that the decision was their own and only four said that the husband had told them to get the pregnancy terminated.

Family members seemed to play a major role in decision-making in SLUM–1 (10 out of 15). In this context, it must be pointed out that more women belonged

Table 4: Decision-making for Induced Abortions

Indicator		*Total Women*
		N= 62
Decision by	Doctor	17
	Family members	15
	Couple	14
	Wife	12
	Husband	4

to joint families and there were more terminations after sex determination in this slum. However, there was no obvious evidence of women here being coerced into abortion (except in one case where a woman was pressured into aborting when she wanted the pregnancy to continue). The women appeared to have accepted the decision with equanimity.

Most of the abortions based on medical advice (15) were from SLUM–2. Also, more women (8 out of 12) from this slum said that the abortion was their own decision. This was especially true in the case of the slum's nuclear families, in which wives played a significant role in deciding whether the pregnancy should be continued or not. This slum also had more women who were employed.

Services used

The majority of abortions took place in private hospitals (48) or in the NGO-run hospital (12); only one each was conducted in the government and municipal tertiary care hospital. Qualified gynaecologists performed all the abortions.

The major determinants in the choice of providers were reputation, vicinity, familiarity and cost of services. Women thought twice about using the government tertiary care hospitals where, according to them, a lot of time is wasted in waiting and in doing the paperwork. Also, these hospitals are not client-friendly and the quality of service they provide is suspect.

> I didn't want a second child so soon. I wanted to have the abortion done at the municipal hospital. My *nanand*, who had an abortion recently, told me that there they do not do abortion for such reasons. She had to go to another place. My husband also believes that any place where service is free will not be good.

In SLUM–1, women who had had multiple abortions and/or had resorted to abortion after sex determination tests reported changing clinics for maintaining secrecy. Confidentiality is thus a major factor when choosing a provider. Women in this slum either directly approached the well-known local or national-level NGO facility, or consulted the NGO outreach health workers, who referred them either to these facilities or to the tertiary care hospital in the area. Some of the women went to a specific NGO-run clinic which they had seen advertised on hoardings, walls, buses, etc.

In SLUM–2, all the abortions were conducted at private gynaecologists' clinics, as these were the only facilities available. The preference for a particular provider depended on the clinic's proximity and the client's familiarity with the provider. Another factor that influenced choice was the recommendation given by family members or friends who had used a particular facility earlier. Explaining why they refrained from using the government tertiary care hospitals, two women said that they preferred not to go to these because a lot of time is wasted in waiting and going through formalities.

Table 5: Service Facility Used

Indicator		*Area*	
		SLUM–1	*SLUM–2*
Provider	Private hospitals	16	32
	Government hospitals	2	0
	NGOs	12	0
Reason for preference	Reputation	Yes	Yes
	Vicinity	No	Yes
	Familiarity	No	Yes
	Cost	Yes	Yes
	Confidentiality	Yes	No

Services received

The quality of services and care these women received was judged in terms of explanations given to them before the procedure, the conduct of preliminary tests or examinations, insistence on husbands' consent, post-procedural advice, follow-up and complications, and their own satisfaction with the services.

More than a third of the women reported ignorance about the method used for their abortion. It was found that not a single woman was told by the doctor exactly what would be done. No explanations were given either to the woman or the accompanying person. It needs to be mentioned here, however, that the women themselves were also not interested in knowing anything about the method or procedural details. Neetu, who is literate, said:

I do not know what the doctor did after I became unconscious. The doctor must have used some machine for abortion. I did not ask anything and the doctor did not volunteer any information. I am unaware about the legality of abortion and different kinds of methods to terminate pregnancy. That does not concern me.

Women did not report any pre-procedural tests other than sonography for foetal sex determination. Women themselves frequently consulted the doctor only after confirming their pregnancy through a urine test at private pathology laboratories. Very few mentioned vaginal examination for confirmation of pregnancy. In fact, Bharati, a literate, employed woman from SLUM–2, recounted a harrowing experience that could perhaps have been avoided had she been thoroughly examined and investigated:

The day after the abortion I developed severe abdominal pain. When I consulted the doctor the next day, she said that it was natural after abortion. She gave me some medicines and advised rest. Even after taking rest and the medicines, I did not get relief. Even my periods did not start. My husband and I went back to the doctor. This time she did a sonography and said, '*Garbhapat vakhate balak nali maan jatu rahyun chhe, jena leedhe tamara jeevne pan jokham chhe*' (During the abortion the foetus has gone into the tube, because of which there is now a danger to your health). She told me that this was a very serious problem and that I would have to undergo an operation, which would cost me Rs 16,000.

Though the doctors did not lay any particular stress on pre-procedural investigations and tests, when it came to taking consent for abortion, many women reported that doctors insisted not only on theirs but also that of the accompanying person(s).

All women reported that doctors did give post-operative advice, but it was no more substantial than prescribing painkillers and rest. But women found even this advice difficult to follow due to the pressures of household work or the need to rejoin work. Very few were advised about the use of contraceptives and only about a third of the women reported being users of any type of contraception. One woman who had undergone six abortions was still a non-user at the time of the interview. There were instances where the husband accompanied the woman for abortion, yet the doctors conspicuously missed advising them to use condoms. Despite all these lapses, most women reported being satisfied with the services they received.

The situation in both slums was very similar except that more women from SLUM–2 were ignorant about the details of the procedure, and more women from SLUM–1 had undergone two-stage abortions, which are done for pregnancies with a gestation of more than twelve weeks. The latter has to be viewed in the context of more sex-determined abortions at a later stage of pregnancy in SLUM–1.

Table 6: Method of Abortion

Indicator	*Area*	
	SLUM–1	*SLUM–2*
Do not know	9	16
By machine	8	8
Curetting	2	2
Two stages	10	6

Cost

Among the women who could recall the cost, the majority of them said that they had paid between Rs 400 and Rs 600 for the abortion. There did not appear to be any standard cost for abortion. Despite advertising the cost of abortion as Rs 150, even the local NGO was charging different women different amounts. Two women who accessed the NGO's service delivery centre after coming to know about it through advertisements, questioned the amount charged. They were told that Rs 150 was only the basic cost, to which other costs are added as and when other tests, procedures or medicines are required. The cost also varied depending on the stage of pregnancy at which abortion was sought and the type of method used.

Heena, a 32-year-old graduate from SLUM–1, described her conversation with the doctor thus:

I already had a son. I did not want a second child, so when I missed my periods I immediately went to 'Mehul' clinic. The doctor there said that a sonography is necessary to confirm the pregnancy. After it was confirmed, he did the abortion. The sonography cost me Rs 200, and the abortion another Rs 500. When I pointed out that the advertisement had said only Rs 150, he told that that is the basic cost; more money is required to cover other expenses like medicines and bed. Since I had no other option, I had to accept.

In SLUM–1, especially in joint families, where the abortion was with the family's consent, the expenses were borne by the in-laws. In SLUM–2, poor socio-economic conditions and the high costs of abortions did not deter women from undergoing abortions in private facilities. Somehow or the other, these women managed to source the amount needed. Over 40 per cent of the women had paid for the expenses from their own personal savings. Money was also raised by them by borrowing from employers, friends, neighbours or relatives, or by pawning jewellery.

During the FGD in SLUM–2, women said that in-laws were often against couples' decisions to abort. They therefore had to conceal the abortion from the in-laws, which is why they could not get any monetary help from them. A considerable number of these women went to their natal homes to get the abortion done. In such situations, the parents paid for the abortion-related expenses.

FINDINGS: PART II

Provider/Facility Profile

In keeping with their mandate, the two tertiary care hospitals offered all curative, preventive and specialist services. The NGOs and private gynaecologists offered obstetric and gynaecological curative and preventive services. The general practitioners dealt with minor curative services, immunisation and other preventive services, while the nurses and *dais* handled only antenatal care and deliveries.

The local NGO reported performing the highest number—150–200—of abortions per month. The national NGO reported 100 to 200 cases, while each of the two tertiary hospitals provided abortion services for 75 to 100 cases per month. The private gynaecologists handled 20–30 abortion cases per month. The general practitioners reported that 20–40 women came to them for abortion every month, while the nurses and *dais* reported only one or two cases. The general practitioners, nurses and *dais*, however, referred the cases which came to them to gynaecologists at private or NGO-run clinics, or to tertiary care hospitals.

The tertiary hospitals and the national NGO were approved centres for abortions, though the local NGO's status could not be ascertained. The rest were not approved centres. However, some private gynaecologists did claim that they had applied for certification two years ago and were still awaiting approval. None of the providers in any of the centres had received any special training to provide abortion-related services. (See Table 7).

Profile of abortion seekers

According to the medical officers from the tertiary hospitals, the majority of women seeking services from their facility were illiterate. Women seeking services from the other facilities belonged to all educational levels. Except for the private gynaecologists, all other providers reported that the women were from a poor socio-economic background. While most providers said that both married and unmarried women from the age group 15–45 years sought abortion, the two NGOs reported a younger age profile, of 20–30 years. The tertiary municipal hospital doctor confessed that they actively discouraged unmarried women from coming to them for abortions, and in the recent past they had (unofficially) also started refusing services to them to avoid problems with the women's relatives.

More that 75 per cent of the abortions were sought in the first trimester, with two-thirds being within the first eight weeks. The *dais* reported that the women who

Table 7: Characteristics of Service Facility/Providers in the Sample

	Government Tertiary	*Municipal Tertiary*	*National NGO*	*Local NGO*	*Private Gynaec.*	*General Practitn.*	*Nurses/ Dais*
Services provided	ALL Curative Preventive Specialist	ALL Curative Preventive Specialist	OB/GY Curative Preventive	OB/GY Curative Preventive	OB/GY Curative Preventive	ALL Curative Preventive	ANC Delivery
Recognised for MTP	Yes	Yes	Yes	??	Not all	No	No
Special training	No	No	No	No	No	No	No
MTP case load	75–100/ month	75–100/ month	100–200/ month	150–200/ month	20–30/ month	20–40/ month	1–2/ month

came to them were generally under 21 and unmarried, and 60 per cent of them came early, in the first trimester.

All service providers confirmed the trend of using termination of pregnancy as a family planning method. According to most private providers, those who want to limit family size undergo abortion as soon as they miss their periods, i.e. within eight weeks, while those terminating pregnancy for spacing undergo abortion between eight and twelve weeks. As Dr Patel, the gynaecologist at the tertiary care hospital, said:

> In my experience, multiparous women seek induced abortions either because the last child is still very young or because they do not want more children. In such cases even her husband and in-laws support termination of pregnancy. Generally, 80 per cent of such women come for induced abortion within 6–8 weeks of pregnancy. Among the 20 per cent who come late in the second trimester at around 14–16 weeks, the delay is usually a result of late decision, money problems, or unawareness about pregnancy due to lactational amenorrhoea.

With the exception of the municipal tertiary hospital, all providers mentioned that though they did not have any documentary evidence, they were certain that many of the abortions that they had conducted were after sex determination. They claimed it was difficult for service providers to find out whether the woman coming for the abortion of an 'unwanted' pregnancy had undergone sex determination elsewhere. In their view, their services were mainly sought for termination of 'unwanted pregnancies', in which providers' responsibility is limited to merely providing the service. The gynaecologist from the government tertiary hospital explained further:

> All pregnancies are regarded as 'wanted' by the service providers; it is the women who have to decide whether they want the pregnancy or not. The client's opinion has to be respected by providers. If the couples come after sex determination, it is their decision. Aborting a female foetus is not wrong. Women should be organised to elevate their status—banning such abortions will not work. In fact, aborting the female foetus is an indicator of women's liberation. The girl is not subjected to ill-treatment and does not become the victim of discrimination after birth. In any case, how would we know whether she has undergone the sex test somewhere else?

One reason for seeking abortions, reported by all providers but not mentioned by women for obvious reasons, was premarital or extramarital pregnancy. A private gynaecologist explained the differences in abortion-seeking between unmarried girls from different socio-economic backgrounds:

> In many communities, the betrothal of girls and boys takes place at a very young age. The girl lives with her parents, but both girl and boy are allowed to go around together. They invariably end up having a physical relationship. Though the community permits their going out together, it does not approve of pregnancy before formal marriage. So these girls come for termination. The community knows that these things happen, but the attempt is to keep it concealed. . . .
>
> On the other hand, there are girls from good socio-economic backgrounds, who are educated and aware but impulsive. They come to the gynaecologist at 13–14 weeks of pregnancy, after having tried all kinds of medicines. The delay is because they are scared. They tell people that they are being operated for an appendix or a lump in the abdomen. Some come with their partner and cinema tickets to justify the three or four hours spent at the facility!

The medical officers at the tertiary hospitals also reported abortions consequent to medical advice, but confessed that these were rare.

While abortions are sought across all caste and community groups, the municipal hospital and the two NGOs reported a high percentage of seekers from minority communities, possibly because they were located closer to the minority localities and also because the residents of these localities were from a poorer background.

On decision-making for abortions, the providers confirmed that the decision is usually made either together by the couple or by the woman alone. Dr Meena, a gynaecologist in SLUM–2 said:

> The decision for MTP is usually that of the woman or her husband's/partner's. The mothers-in-law are kept in the dark as this is a conservative community and has a strong belief that children are god's gift and one should not try to limit their number. Also, the mothers-in-law in this community are very domineering, and have a

strong belief that the daughter-in-law should have at least two sons.

Pre-abortion services

The providers admitted that pre-abortion services mainly comprise a physical examination and enquiries about medical and obstetric history. They did not do any internal check-ups or ask for any investigations, as these tend to put off the women. Instead, they depended on the history of amenorrhoea, a positive urine test or sonography report and the woman's consent, and, in the case of anticipated problems, the presence and consent of relatives or accompanying persons. Except for the government tertiary hospital, none of the other providers felt that pre-abortion services are warranted or mandatory. The medical officer at the government tertiary hospital was the sole exception who said that at least a blood group test needs to be done as women who are Rh-negative require an anti-D injection even after abortion.

When specifically questioned about why they ask for the consent of people other than the woman when it is not mandatory under the Act, the medical officer at the national-level NGO said:

> Every surgical procedure, however minor, has the potential of becoming complicated. We do not insist on consent of the accompanying person, but we do want someone from the family to be around. The consent of this person is for surgical procedure under anaesthesia, not for the abortion itself.

The providers also felt that the women themselves were not particularly bothered about issues like consent or privacy. They therefore made no special arrangements for maintaining privacy. As the medical officer at the government tertiary care hospital put it:

> Privacy and confidentiality is not an issue with women. After all, where can you get more anonymity than at a public hospital where thousands are milling around in the OPD? They are not hesitant about consulting male gynaecologists either.

Abortion methods and process

There was unanimity amongst the providers regarding the methods 'recommended' for abortions at different stages of pregnancy. They mentioned that manual vacuum aspiration or MVA is recommended for pregnancies under six weeks, and electric vacuum aspiration—usually under local, though in rare cases under general anaesthesia—for 7–12 week pregnancies. For late first trimester and second trimester pregnancies, i.e. at 14–20 weeks, the recommended procedures are all two-stage. The first stage comprises of a Prostaglandin injection, per-vaginal Laminaria tent insertion, per-cervical instillation of 150 cc of Ethacridine lactate using Foley's catheter, or local application of Prostaglandin/Cerviprim jelly to ripen/dilate the cervix. This is followed by a Pitocin/Sintocin drip to induce expulsion of the products of conception, or a dilatation and evacuation or curettage (DE/DC) process, again under local but sometimes under general anaesthesia. For the rare abortions performed beyond 20 weeks, the recommended method is either intra-amniotic Prostaglandin (PGF12) injection or, in rare cases, hysterectomy.

Though these methods were mentioned as recommended and suitable, providers pointed out that the actual use of these methods depends on factors other than just the gestation period. For example, some providers, particularly those in the private sector, did not use the electric VA as the electricity supply in the area where they practised was uncertain. Again, some did not recommend the MVA or electric VA beyond eight weeks as, according to them, it is at this time that bones begin to develop in the foetus, which makes aspiration difficult. One private doctor said:

> The 12–14 week window is a problem period. During this period, it is too late to use the methods used in earlier stages of pregnancy, and too early to use the methods used at later stages. I ask my clients to wait for 14 weeks to get over before I do the abortion.

In addition, the providers also had their own personal preferences regarding the methods to be used. According to a private male gynaecologist:

> I use only the D&E method. I prefer to see what I do, so I also use laparoscopic methods. I do not recommend RU 486 for the same reason. But my Jain clients prefer the medical method for termination of pregnancy. So in such cases I prescribe RU 486.

Whatever their views on the methods used, all providers described a more or less similar pattern and route of service use for married and unmarried women. According to a private gynaecologist:

Married women usually want to terminate the pregnancy to delay the first childbirth, space the next childbirth, get rid of female foetus, or for career reasons. In Gujarat, many women who get married to non-resident Indians also get it done because they fear that their visas might be rejected. In very rare cases are women advised to get their pregnancy terminated for medical reasons. All the abortions are usually with the husbands' approval. Depending on the reason for abortion, the older members of the family may or may not be told about the decision. These women come very early, usually within fifteen days of missing their periods. Some, despite being literate and aware, do try traditional methods like consuming 'hot' foods or Primolute/Epiforte tablets. When they do not get withdrawal bleeding, they themselves go to pathology labs and get their urine tested. A few also try RU 486, a pill that is now available over the counter in some shops. The others consult their GPs or a gynaecologist. They get admitted on that very day, and thus get the abortion done on demand. They insist on being discharged within a couple of hours.

The unmarried girls, on the other hand, come for termination of their illegitimate pregnancy, or for visa and career reasons. They usually come alone or with their mother or close friend; it is very rare for the partner to accompany them. Usually, the rest of the family is kept in the dark. They come a little late, at least a month after the due date of the period. They, too, first try out 'hot' foods or over-the-counter medicines. When these fail, they consult the local nurse or the GP. They are then referred to the gynaecologists. The gynaecologists at government hospitals conduct an 'inquisition', but we in the private sector do not. We just provide the services and discharge the girls as early as possible, keeping in mind the social repercussions of in-door admission.

Post-abortion care

The providers said that the duration of women's stay in the hospital depends on the period of gestation and the method used. Typically, the duration increases exponentially with the period of gestation. From less than half-an-hour for a less-than-eight weeks' gestation, it goes up to two to three days for over 16 weeks' gestation.

Post-abortion care mainly comprises a tetanus toxoid injection, antibiotics, anti-inflammatory pills and painkillers. Two private gynaecologists also mentioned giving the women Mala D. They do not ask the women to come for follow-up visits if there are no complications. The counselling is limited to explaining the possibility of post-abortion sterility to primiparas, and the consequences of repeat abortions to frequent users of abortions. The providers, particularly those in tertiary hospitals, insisted that they believe in contraceptive counselling since in any case the termination was most often used for family planning reasons. However, one also admitted that:

> As such, most providers in government hospitals do not have much time to spend with the client, so counselling is not effective. And private hospitals do not have dedicated staff or incentives to do contraceptive or consequence-related counselling. Further, hospitals do not have any system to audit counselling and its effect.

Table 8: Hospital Stay

Period of Gestation	*Hospital Stay*
<8 weeks	<1/2 hour
9–12 weeks	2–3 hours
13 weeks	Half a day
14–16 weeks	Full day
>16 weeks	2–3 days

Cost

According to the providers, the cost of abortion varies depending on the type of provider, the gestation period and the method used. The medical officers at the tertiary hospitals quoted the lowest charge. Being government-run, these hospitals are expected to provide free services, but, as the medical officers acknowledged, women do have to bear some costs as they have to pay for medicines which, when not in stock at the hospital, need to be purchased from outside.

The private gynaecologists quoted the highest charge. The local NGO advertised abortion services at Rs 150,

Table 9: Cost

Facility	*Cost in Rupees*
Nurse	500–700
General practitioners	700–1500
Private gynaecologists	1st trimester: 750–1500
	2nd trimester: 2500–5000
Local NGO	1st trimester: 350–400
	2nd trimester: 1500–2000
National NGO	1st trimester: 400
	2nd trimester: 800
Tertiary hospitals	Free–300

but admitted that the total cost could go up to as high as fifteen times that, confirming what the women had mentioned in their interviews.

Providers had very strong and divergent views on the issue of cost. The medical officer at one of the tertiary hospitals was vehemently against abortion being offered as a free service. He said:

> It should not be done free of cost, except for Below Poverty Line (BPL) families. Otherwise people do not use contraception since they feel that whenever they do not want a pregnancy, there is an easy remedy available.

On the other hand, his counterpart at the municipal tertiary hospital was of a contrary view. According to him:

> Abortions should come under the family planning programme and should be totally free of cost. It should be accepted as a family planning method.

The private gynaecologists were dead against any standardisation or regulation of cost. One of them categorically stated:

> Cost cannot be advertised correctly nor can it be regulated. It depends on the gestation, the methods used, and the risks taken by the provider.

They also felt that as women were willing to spend the money, there was no reason for anyone, including the government, to interfere in what they charged.

Quality of services

Providers were of the opinion that most women were satisfied with their services and about a third of them had another abortion within a year. Usually, the women would go to a new place for the next abortion, but this was not always the case. However, two providers, who were more candid, also said that women really had no option and therefore, despite all the problems they might face, had to be satisfied with whatever services they received. None of the providers mentioned coming across any instance of death or sterility due to abortion during their careers. But they did sometimes witness cases of incomplete abortion, spotting or bleeding and, very occasionally, a woman with a pelvic infection, abdominal pain or perforation as a consequence of abortion. These, according to them, are bound to occur when services are not freely available and women are unaware of the availability of qualified providers.

Experiences

The providers claimed that most women do not feel any permanent remorse after terminating a pregnancy. According to private gynaecologists, a few suffer from something called *'smashan vairagya'* (temporary remorse). To quote one of them:

> Women's initial feeling is not good. They do not like what they have done. They have what we call a '*shamshan vairagya*' feeling. They say that they have committed a '*paap*' (sin). But they soon forget about it and 20–30 per cent come back for a repeat abortion. The married ones have become fairly hardened. They come back to the same doctor repeatedly. But unmarried girls who have repeat abortions go to different providers.

Not all providers are happy with having to provide abortion services. Two mentioned conscience problems, but also stated that they have no option but to provide services for economic reasons. They also talked about problems with the authorities as well as with the families of some women who seek abortion without their knowledge. A former medical officer at the national-level NGO spoke about how she felt:

> The salary was not commensurate with the job requirement. I was paid only Rs 8,000 per month. To add to it, I would come back home with a heavy heart. I would picture the small hands and feet again and again. I was mentally very traumatised and was always overcome by feelings of guilt. I never enjoyed my work. This is the reason why no doctor stays there for long.

Another private gynaecologist, who has discontinued the service, said:

> The MTP Act does not permit abortions on demand and rightly so. I do not conduct abortions any more. All my clients are educated and from the upper class. I do not want to correct their mistakes. I always encourage contraceptive use. They should avoid the situation in the first place.

Views on available services and MTP Act

The universal view was that abortion services should be and are widely available, but that very few providers in the private sector actually have the technical approval for providing the services. The entire training and approval procedure is unrealistic and needs to be revised. The training is unnecessary and impractical for private

doctors. The certification process involves administrative delays and is tedious. The primary visit by the approving authority to the centre is usually a year after the application and costs around Rs 800 to Rs 1,000. But after that there is no follow-up action despite repeated submissions. The private providers mentioned that the professional body of obstetricians and gynaecologists has presented their problems to the appropriate authorities, but has yet to receive a reply.

Since they find it difficult to refuse women the service, they feel that abortion should be included in the government's family planning programme because, in any case, the services are being used primarily for family planning reasons. There is also no need to standardise the requirements and procedures. They feel that the MTP Act is open to interpretation and therefore the government should post its trust in qualified allopathic providers, i.e. gynaecologists. They are also insistent that the consent of accompanying persons must be taken for surgical procedures and women activists should not view this as undermining women's autonomy.

The paperwork, too, needs to be rationalised. Record maintenance should be limited to terminations after sex determination or suspicion of sex determination. They feel that accountability for any wrongdoing should not stop with the provider but should go right up to the top, i.e. the concerned government department or appropriate authority. In the absence of safeguards for doctors, and with the increasing use of the Consumer Protection Act (CPA), it would not be surprising if the medical lobby ensures that the services are either not easily available or that no doctors are punished. They also feel that the accountability of providers should be restricted to technical mistakes. They should not be hauled up for having provided the services in contravention of the Act. According to one of them:

> The Act allows women to undergo abortion as many times as they wish. This is not good; it should not be so liberal. The implementation of the Act is poor as there is a lack of accountability, which should be there at all levels—from the lowest cadre to the Health Minister. Qualified providers like me should be protected against legal hassles. Also, there should be proper selection of the health provider. The prevalent view of training paramedics is untenable. Who will be accountable for any problems? With the Consumer Protection Act, even legal services will soon be unavailable.

Another doctor said:

> In the case of unmarried girls, the practice of obtaining the guardian's signature is difficult to get rid of, as the providers at government hospitals are not guarded against any threats. Of course, any legal action is meaningless because medical solidarity will not allow a doctor to be punished. I feel that providers like us can be held responsible only for medical or technical aspects. The client should be held responsible for the financial, social and psychological aspects. The responsibility for sex-determined abortion is also the client's.

CONCLUSION

Our data shows that awareness about the possibility of terminating an unwanted pregnancy was universal and high, as was awareness about availability of services. A substantial number of the women interviewed viewed abortion as a method to control the family size and space children. They neither knew that this was not within the legal mandate of the MTP Act, nor did they seem particularly concerned about it. There was, however, reasonable awareness about termination of pregnancies after sex determination being illegal. While the decision for abortion to regulate family size was not necessarily with the knowledge or consent of the elders in the family, abortion after sex determination was a family decision, often made with the active participation of the women themselves. It appears that the practice of abortion after sex determination was more common among better-off and educated women, perhaps because sonography itself is an expensive proposition for most. However, this observation may not stand statistical scrutiny, as our sample was small and largely purposive.

The majority of women took the decision to terminate within the first eight weeks of pregnancy. They also admitted to trying out over-the-counter medicines like Epiforte/Primolute for withdrawal bleeding to rule out delayed periods. This practice extended across all educational and economic classes. Once the tablets failed to yield the desired result, women went to qualified gynaecologists either directly or through referrals by general practitioners or local *dais*. Not a single woman reported going to quacks or *dais* for abortion or what they called 'curetting'. Awareness about the need to go to qualified gynaecologists was thus high and their services were availed irrespective of costs and the women's status.

Women accessed gynaecologists who admitted them, conducted the abortion and discharged them on the same day. Pre-abortion investigations and examinations were perfunctory and in the absence of complications, post-abortion follow-ups were non-existent. Counselling was not seen as a critical element of the service either by the women or the providers. The process seemed to be predominantly demand-driven, with the women dictating some of the terms such as hospital stay and post-abortion care, with a total disregard for medical norms or requirements. These were also some of the reasons why private services were preferred. Privacy, confidentiality and, to some extent, costs were often quoted as reasons for preferring private over government facilities. Our study seems to indicate that the reputation and flexibility of private providers to meet the demands of women and their families in complete contravention of the MTP Act also play a sizeable role.

The providers corroborated most of the information reported by the women except with regard to two critical issues. First, they claimed that they do not do sex determination tests and if the woman had had it done elsewhere, there was no way for them to find out about this. And second, that they usually do a complete physical examination and counselling before actually conducting the abortion. The providers, mainly private gynaecologists, also spoke of the constraints under which they worked. The undue delays in the certification process meant that the facilities of most providers who were interviewed were not 'approved' centres and, by virtue of this, they were forced to provide services which, though essentially safe, were deemed illegal. In their view, the unrealistic requirements and impractical stipulations for provision of services made proper implementation of the Act practically impossible. They likened the authorities' deliberate disregard of the use of abortion for family planning purposes to an ostrich burying its head in the sand.

To conclude, in view of the changing social scenario wherein women are increasingly using abortion to terminate pregnancies for reasons other than those mentioned in the Act, and since over-the-counter medical abortion pills are freely available, the Act needs to be revised to ensure that it is in consonance with the field realities. On their part, professional bodies of providers, particularly gynaecologists, need to come up with measures to handle the laxity of providers in abiding by the medical code of ethics while terminating pregnancies after sex determination. Thus, policy-makers and service providers need to work together to make the Act more realistic and implementable.

Limitations of the Study

The initial site selected for the study was a slum near the old city of Ahmedabad. However, the social and communal unrest prevailing in the city when the study commenced made it impossible to conduct interviews in that area. As a result, though the largest number of women who used the facilities in SLUM–1, i.e. the slum with all the tertiary and NGO facilities, were from the community residing in this area, their views could not be ascertained.

Since we used a qualitative methodology, the results of the study can by no means be generalised. Further, given the sensitivity of the topic, our respondents were virtually self-selected and therefore may not represent the entire spectrum of the users of these services.

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Women, Work and Abortion Practices

Kancheepuram District, Tamilnadu

ANANDHI S.

> Abortion is a necessary, though far from sufficient, condition of women's essential right and need, not only for bodily health and self-determination, but also for control over their work, their sexuality, and their relations with others—including existing children. From this perspective, abortion conducted under safe, affordable, and stigma-free conditions is neither a necessary evil nor a matter of private choice. Rather, it is a positive benefit that society has an obligation to provide to all who seek it, just as it provides education and health benefits.
>
> (Petchesky 1986: 387)

INTRODUCTION

Studies on abortion in India have been conducted primarily on aspects such as the quality of abortion care and services and post-abortion complications. Some studies have developed a critique of the MTP (Medical Termination of Pregnancy) Act.[1] However, there is virtually no study that locates abortion in the larger context of production, reproduction and sexuality.

As far as Tamil Nadu is concerned, there have been a few quantitative surveys on the incidence of abortion, done mainly in the context of fertility decline. Most of them document how abortion is used as a method of contraception in order to achieve desired demographic objectives.[2] But even these, while analysing the 'structural' factors that have led to the utilisation of abortion as a method of birth or population control, fail to pay attention to either the 'personal' factors involved or the process through which women arrive at the decision to abort. We have to turn to women's narratives of their experience of abortion to learn about the processes and constraints involved in their taking such a decision.

Further, the studies do not take into account how these 'structural factors' translate into actual personal-level processes of reproductive 'choice'/non-choice for and by women. A reformulation of the issue of abortion in these terms would conceptualise women not as passive victims of medical and state policies of reproductive control, but as active—though not always entirely free—agents in reworking their reproductive interests. In other words, even while their 'choice' and resistance are conditioned by 'external structural' factors, women have to be recovered as active agents of their fertility and reproductive choices, however circumscribed their agency and choices are.

Our emphasis on women's agency, however, is not to minimise or undermine the fact that women's decision to abort and their experience of abortion are simultaneously controlled and mediated by larger institutions (the state, medical institutions, patriarchal families) and by structural conditions and processes (socio-economic transition, sexual division of labour). As Rosalind Petchesky argues, women's access to material resources in the form of landownership and employment outside

the domestic sphere does effectively change their conception of reproductive control, as also the structures of knowledge about fertility control among them (Petchesky 1986: 7). For instance, the logic of work and work conditions might force women to choose abortion as an alternative to losing their job. Similarly, their access to industrial work and the new collectivity of women this engenders might generate an alternative knowledge system about abortion practices. Besides, the very meaning of abortion derives 'from the specific historical and political context in which it occurs and the circumstances (class, marital status, employment conditions) of the woman involved' (ibid.: 9). Abortion as women's choice or as a symbol of their reproductive freedom is always entangled with various patriarchal structures and social conditions. Therefore, even while our emphasis is on women's consciousness and agency in the practice of abortion, we would not abstract the concept of the 'right to choose' or 'reproductive right' from the social and material conditions under which the choices are made.

ABORTION IN TAMIL NADU: TWO SCENARIOS

From the early 1980s, Tamil Nadu has been witnessing a sharp decline in fertility rate essentially due to a strategy of family limitation, especially among the younger age group which largely seems to have followed terminal methods like abortion and sterilisation. As Nagaraj explains, fertility decline in Tamil Nadu has not been accompanied by factors such as increase in age at marriage or longer intervals between births. Instead, it has been achieved through 'bunching' births around shorter birth intervals, with a high proportion of pregnancies-at-risk and high levels of pregnancy wastage (Nagaraj 2000).

Significantly, rapid fertility decline has also been made possible by the near-universal knowledge of contraception among married women in Tamil Nadu. According to the *National Family Health Survey (1998–99)*, 100 per cent of currently married women in Tamil Nadu know at least one method of contraception (IPS 2001). Although the extent of women's knowledge about modern methods of contraception is significantly higher than that of traditional methods, they seem to know more about sterilisation and clinical abortions in the former category. According to the survey, sterilisation among women accounted for 87 per cent of total contraceptive prevalence. Equally, as the survey notes, not only knowledge but also the use of contraceptive methods by women in Tamil Nadu is as high as 52.1 per cent, with the percentage of women using sterilisation alone accounting for 45.2 per cent.

At 11.4 per cent, the incidence of abortion—i.e. abortion in percentage of pregnancies—is the highest in Tamil Nadu compared to the all-India figure of 6.1 per cent (ibid.).[3] In particular, the induced abortion rate for Tamil Nadu is as high as 5.2 per cent, while the all-India rate is only 1.7 per cent.[4] The total number of reported abortions in Tamil Nadu is 42,364, with 73.8 per cent of them occurring among married women of below 30 years. (A study on abortion in Kerala, too, notes that over a period of time an increased proportion of abortions were carried out among younger women, i.e. two-thirds of the abortions were among women below 30 [Rajan et al. 2000: 76].) All this points to the fact that abortion has a big presence in reproductive control and choice in Tamil Nadu. It also indicates that abortion is widely practised by married women as a birth control or birth spacing method. As many studies have already argued, the state's fertility control programme has always promoted abortion along with sterilisation as an important method of population control.

The second scenario that this study takes up for analysis is the practice of abortion by unmarried young girls in the context of changing production relations and women's employment in pharmaceutical industries. An important feature of the recent economic transformation in Tamil Nadu has been the employment of an increasing number of women in the informal sector industries. In contrast, men, in the absence of agricultural work, are unable to find regular jobs in the growing industrial sector. The consequent reversal of gender roles, by which men no longer perform the function of 'provider', has been a significant factor in changing women's reproductive relations and widening their access to abortion. On the one hand, the unmarried young women's status as earner/provider has led to increased surveillance of and control over their sexuality by the men in their families,[5] and the employment of new notions of sexual morality and social dishonour associated with practices like abortion. On the other, their mobility to the site of work and the act of earning has enabled them to negotiate the disempowering conditions of their sexuality. The practice of abortion by unmarried working girls is thus mediated by this specific condition of production and reproduction relations.

OBJECTIVES OF THE STUDY

Against this general background, our study attempts to understand the practice of abortion among married and unmarried women in a region where the recent transformation of the local economy is drawing more and more women into industrial employment. In the case of married women, the study explores how they negotiate 'structural factors' such as the state's policy of population control, the imposition of family planning methods by medical institutions and patriarchal family relations, through their personal 'choice' of abortion. In other words, the study analyses (*a*) how married women negotiate and rework their 'reproductive interest'[6] through abortion; and (*b*) what reasons other than birth spacing those women advanced for having abortions (e.g., women might link their abortion to childcare responsibility, son preference, marital violence, conditions of work, etc.). Simultaneously, by retrieving women's own perspectives and reasons for abortion, the study attempts to identify and understand the social and cultural conditions and values that facilitate and/or constrain women's 'choice' of abortion.

In the case of unmarried women, especially young, unmarried working girls, the study attempts to explore how specific production relations that deny women labour rights and economic security produce the material bases for exercising (or not) their reproductive rights.[7] More specifically, the study analyses how unmarried young women's location in production mediates their relations of reproduction. While women's location in 'production' helps us to explore structural factors, their action in the domain of reproduction gives us an understanding of 'personal' factors and their interconnectedness with 'structural' factors.

THE STUDY AREA

Kancheepuram district, which adjoins as well as forms part of the Chennai city agglomeration, is being swiftly transformed from an agrarian into an industrial economy.[8] Not only is the occupational pattern of the population undergoing change, but also the most vital economic resource of the region—agricultural land—is being increasingly utilised for non-agricultural purposes. One important indicator of this transition from an agrarian to an industrial system is the shift in the occupational profile of the population. If we look at the census reports for Chengalpattu district,[9] we see a decline from 1981 to 1991 in the proportion of main workers in agriculture (either as cultivators or as agricultural labourers) to the total workers. While cultivators constituted 22 per cent of the main workers in 1981, their proportion had reduced to 16 per cent in 1991. Alongside, there was a significant increase in the share of 'other workers' (indicating the growth of employment in non-agricultural and non-household sectors), from 39 per cent of the main workers in 1981 to 44 per cent in 1991 and 60 per cent in 2001. The increase in the percentage share of 'other workers' also coincided with the process of industrialisation in the district, particularly in and around the Chennai metropolitan area, indicating a rise in industrial employment.

In 1985, an industrial estate meant exclusively for small and medium-scale pharmaceutical units was started in Alathur village in Chengalpattu taluk, adjacent to the Thiruporur town panchayat. Around that time, the Small Industries Development Corporation (SIDC) had built about 50 production units on the estate. These employed about 3,000 women workers from neighbouring villages. In the meanwhile, many other types of industrial units also came up in the region. With the explosion in garment and leather exports, export-oriented units, which existed even earlier, multiplied in large numbers. In addition, software and chemical units, especially in the 1990s, absorbed a large proportion of unskilled workers. A significant aspect of pharmaceutical units is their recruitment of women in large numbers, especially young unmarried *dalit* girls from the age of 14, which is well below the legal age for employment. Much of the female labour in these industries is employed as daily or contract labour on a temporary basis. They receive a very low wage, ranging from Rs 21 to Rs 35 a day, without any benefits such as medical allowance.

By 1999, there was a marked increase in the number of women employed by pharmaceutical companies, especially from four villages surrounding the Alathur estate.[10] It is these villages that we chose as our study area. Abortion in this region is also widely prevalent. A recent study (1996–97) of women's health in Thiruporur and Thirukazhukundrum blocks indicates that out of 4,507 women surveyed, 67 per cent had induced abortions in hospitals, 19 per cent had induced abortions through indigenous methods, 10 per cent had used 'injection' and 4 per cent had availed oral

tablets.[11] While these were reported cases of abortion for married women, the incidence of unmarried young women accessing abortion facilities in private clinics, which is increasing, is often under-reported.

RESEARCH METHODOLOGY

We undertook this study mainly to understand (*a*) how married women seek abortion as a method of reworking their reproductive interest, and (*b*) how its practice among unmarried working girls is closely linked with their production relations. Since our research involved mapping women's perceptions and their experience of abortion, we adopted a qualitative survey method that involved the following processes.

Towards Fieldwork

We began by training our field researchers in different types of qualitative research, caste, gender and production relations in the study villages, issues of abortion and the need for obtaining the informed consent of women participating in the study. A local ethics committee was formed, consisting of senior researchers and academics working on reproductive health issues and experts trained in carrying out field surveys.

Since the researchers were complete novices, we felt it necessary to strengthen their understanding of such issues as the abortion law and how it works, the availability of abortion services, the politics of fertility control and the use of abortion as a birth spacing method in Tamilnadu. We therefore collected and documented existing material on these issues, which we shared with our researchers and also used as reference material while writing this report.

The Field Survey: Selection of Sites and Participants

We begin by briefly describing the process involved and the problems encountered in the selection of participants for different methods of data collection. Since the study is primarily about women who work in pharmaceutical companies, our first step was to approach various pharmaceutical units (about 23 at the time of the study) located in the Alathur industrial estate for a list of women working in their units, along with some details about their age, salary and the village(s) to which they belonged. Because of the 'unorganised' nature of these industries, which employ men and women mostly as contract or daily wage labourers, it was easy for many of them to deny us access to such information on the grounds that they do not maintain records for temporary employees. Even among those who did provide us with the requisite names, some furnished faulty information about salaries and so on, as they were apprehensive about our motive for wanting a workers' list.

Since we were unable to obtain information about an official list of workers from these units, we informally interviewed the secretary of the Pharma association, who provided us with information about villages from where a large number of women come to work in different companies on the Alathur estate. Based on this, we selected four villages: Puthur, located just behind the estate at a distance of half-a-kilometre; Kaleri, which is situated alongside the industry, about 1 km away;[12] Mandalam, which is about 3 km away from the estate; and Pennavur, which is at a distance of about 6 km. According to our survey, Puthur has 309 households, with a total population of 1,433. Of these, 877 are *dalits*, and among them 422 are women. Pennavur has a total population of 4,258 with 608 households. The *dalit* population here is 1,369, with 704 women among them. Mandalam has 739 households with a population numbering 3,286. Of these 1,659 are *dalits*, among whom 422 are women. Kaleri's population, numbering 589, is entirely *dalit* with 133 households. The population of *dalit* women is 289. Within each village, we selected only *dalit* women as participants, not only because the *dalit* population in these villages is higher than that of other castes, but also because these women comprise the largest group employed by the companies.

Abortion is a sensitive issue that is even now shrouded in secrecy, especially among unmarried young girls. We therefore decided to obtain first-level information about women who have undergone abortion and the possible reasons for its increasing rate—especially in these villages—from different groups of women who interact closely with women living in our study area. We began by contacting the village health nurses (VHNs) for the four study villages to obtain information about (*a*) the role that they play in these villages and their perceptions about abortion and family planning, and (*b*) women's reproductive practices in their area of work. Our next batch of key informants comprised elected women representatives from the local panchayats. They introduced the researchers to the birth attendants in each of the four villages, from whom we gathered information about private clinics and unregistered doctors

who provide abortion services to unmarried women.

With the help of ward members, we were able to prepare a population profile for each of the study villages, as well as a list of women who work in different pharmaceutical companies in Alathur estate, along with details such as their age, marital status, family background and salary scale.

The Research Method

We used four different qualitative survey methods to collect data.

Focus group discussions (FGDs)

FGDs were organised in all four villages among women of varying age groups to find out whether there were any differences in their perception of the practice of abortion. Two FGDs were held in each village, with elderly women aged between 45 and 65 years and with middle-aged women in the 25–45 age group. We were able to hold FGDs (one per village) with unmarried young women—who work for pharmaceutical companies and are between 17 and 22 years old—in only two villages.[13] Each FGD had six to eight participants.

The discussions with elderly women, most of whom were married (though some were widows), centred around their experience and knowledge of abortion and the changes that have come about in the practice of reproductive control, particularly those that they have witnessed after women began to work in pharmaceutical companies. We also spoke about issues like decision-making within the family vis-à-vis fertility regulation and women's control over the family economy.

With middle-aged married women, the discussions focused on their perception of the linkage between women's work and fertility control, mainly their reading of the changes that have occurred in women's work and reproductive practices. Our talks centred around their personal experience of abortion, myths relating to abortion, the methods used, sex selection and their knowledge of family planning methods. We also discussed how different agencies, such as hospitals, pharmaceutical companies and village panchayats, other than their own family, are intervening and regulating their reproductive practices.

The FGDs with unmarried girls working in pharmaceutical companies focused on the conditions and nature of their work and their experience of it, their roles and responsibilities, their role in decision-making within the family and their views on female sexuality and reproductive health. While abortion was also included in the discussions, researchers consciously avoided talking about individual experiences of abortion or about individuals who have undergone abortion.

In-depth interviews

Three categories of in-depth interviews were conducted: one was with married and unmarried young women in the 16–30 age group who are working in pharmaceutical companies and have not undergone abortion; the second was with married women who have undergone abortion and among whom some are working in the companies; the third category of interviews was with young women who are now married but had undergone premarital abortion (this group of women were identified through FGDs with older and middle-aged married women and also through our key informants).

Interviews with key informants

A fourth category of in-depth interviews, which were informal and unstructured, was conducted with key informants, such as service providers. These included registered (three) and unregistered private doctors (two), the VHNs working in the four study villages, birth attendants in two of the study villages, women panchayat leaders and women's *sangam* activists. The doctors were the main source of information about the status of abortion practice, especially among working young girls who are unmarried, and the changes they have observed in the lives of young unmarried women, particularly in respect to their attitude towards abortion. The VHNs,

Table 1: Sample Survey of the Study

FGDs	*In-depth Interviews*				
Elderly, middle-aged and unmarried (FGDs 10 x 6 = 60)	Key informants	Unmarried working women	Married working women	Married non-working women	Married abortion cases
60	15	50	20	20	10

birth attendants and women panchayat leaders provided us with detailed information about the sexual relations of young unmarried girls and the abortion practices in the villages where they work.

Data processing and analysis

Field data, covering FGDs, interviews and researchers' observations, were jotted down as short notes in Tamil during every field visit, with researchers filling in the details later on the same day. Simultaneously translated into English by the research coordinator, these extensive notes were word-processed and later analysed with the help of a software programme called Atlas-ti.

Ethical Issues: Dilemmas and Concerns

Since abortion is a sensitive issue, we had to inform the participants about the study, its aims and possible outcome. As a first step, we outlined the objectives of the study, remarking on the common occurrence of abortion and its legality, and suggesting that it is the right of young girls, if they wish, to terminate pregnancy. However, as far as possible, we prudently avoided using the word 'abortion' whilst speaking with young girls, especially in the presence of their family members; it was necessary to do this, given that our social mores prohibit unmarried women from engaging in sexual activity. The researchers then explained the confidentiality clause, and also the right of respondents to express their willingness or unwillingness to participate in interviews and discussions. After clarifying how much assistance (both moral and material)[14] it was possible for the researchers to provide, we sought the consent of the participants. However, we could only obtain their oral consent, as participants were unwilling to give anything in writing.

While translating and analysing the data, as well as writing this report, we have taken utmost care to retain the women's voices and views. For the sake of preserving confidentiality, however, we have withheld the names of the women and changed the names of the villages to which they belong.

Altogether, we see our research process as one way of endorsing women's experience, exchanging ideas and engaging in action towards empowering women. For instance, our research enabled the respondents to rethink their notions of sexuality, gender and reproduction. The reaction of women of different age groups across the four sites is very revealing: they often exclaimed that: '*Nobody has asked our opinion before*'; '*Nobody has ever asked about our views on reproduction or about our sexuality before*'; or '*Before you discussed all these issues we did not think that they can be talked about openly among women without having to resort to some secret codes and meanings*'.

However, the study suffers from several shortcomings, most of which are related to the limitations imposed by prevailing social and cultural norms and the researchers' knowledge of health issues in general and abortion in particular. First and foremost, we could not talk to unmarried young girls about their experience of abortion, not because abortion is considered a sin but because of the social stigma and dishonour attached to premarital sexual relationships. Therefore, we had to base our analysis of their sexuality and abortion practices on the observations/perceptions provided to us by other women. In other words, we do not have the direct testimony of young unmarried women who have undergone abortion, to understand how their personal experience of abortion has shaped their views on reproductive rights. Secondly, being social scientists, our researchers had to rely on medical personnel's views on abortion, as also their perceptions of what are wrong and right methods. This meant that we could not engage with the participants on the question of abortion-related complications, such as the stage of pregnancy when women can safely abort or deaths due to abortion.

FINDINGS AND ANALYSIS

The findings and analysis of our field survey have been grouped into two sections. The first deals with the experiences and perceptions of abortion of three generations of married women. It details the changes as expressed in the women's narratives of sexuality, fertility control and abortion over three generations and analyses how women negotiate certain social and cultural values and constitute their agency vis-à-vis abortion.

The second section deals mainly with unmarried working women and abortion. The first part of this section maps out in detail the conditions of work and production relations in the pharmaceutical companies, which forms the context for the analysis of abortion practices among unmarried working women. The second part traces the link between women's work in the companies and the practice of abortion by young unmarried girls through an analysis of different narratives

of their sexuality and experience of abortion. The concluding part of the report brings together the different strands and elaborates on some of the discussions related to women's agency and reproductive rights in the context of abortion.

Married Women and Abortion

In this section, we analyse how married women negotiate certain social and cultural conditions to constitute their own agency in abortion. We also discuss in detail women's changing perceptions with regard to abortion and sexuality; how women arrive at the decision of abortion and in what way *that process* exemplifies women's sense of reproductive entitlement. This is done by analysing the narrations by married women of their experience(s) of abortion and their reasons for seeking it.

Sexuality, shame and abortion

While discussing their experience and perception of abortion, the first generation of women in the study villages unanimously agreed that even before legislation, abortion was as widely practised as it is now. They also remarked that in those days, despite the fact that abortion was illegal, women did not feel guilty or sad about aborting the foetus since this was not considered a sin. But what they perceived as the difference between then and now is the manner in which abortion is linked to the question of female sexuality, honour and shame. Earlier, it had hardly anything to do with the public notion of family limitation. According to them, birth control had more to do with individual women's desire to do away with child care responsibilities since they were already burdened with domestic chores as well as outside work. Abortion in such cases was not related to informed notions of family size, since a large family with many children was considered to be a credit to the women. Narrating her experience, a 65-year-old woman stated:

> In those days, it was not considered a shame to have many children. It was a shame only if you had an abortion. Unlike childbirth, pregnancy was always associated with female sexual desire. Having an abortion meant that a woman was exposing her sexual activities and was bound to be condemned for it. So, we were scared of abortion not for health reasons but for public condemnation of our sexual activities. Only for that reason, we had to keep it a secret. Nowadays, it is a shame only if you have many children. Abortion is no longer shameful. That is why the younger lot is marching to the hospital to have abortions.

Another elderly woman from one of the study villages reiterated the same sentiment. She stated that in their time secrecy had nothing to do with abortion but everything to do with sexuality. According to her, honour and shame interfered with their decision to abort and the method they adopted for it. In this context, the method chosen was indicative of the woman's social status during pregnancy and her desperation to get rid of the foetus.

> My aunt had 11 children and she aborted twice using the normal method which most married women of those days used. They mixed black cumin seed powder with palm sugar and made a ball. They would take this everyday until the foetus dissolved or came out. Nobody felt guilty about getting rid of the foetus and women were healthy and normal after the abortion. But some preparations of abortion medicines claimed the life of women. In our village, a widow who conceived felt ashamed about it and she prepared a spurious pickle containing *Chitramoolam* roots and shards of glass. When she consumed some of this mixture, the glass pierced her intestine and killed her.

Even the second generation of women (the middle-aged), though exposed to the state's family planning propaganda, did not consider abortion as a method of contraception or spacing. Frequent childbirth was not yet considered a burden for women or an impediment to their standard of living. But frequent pregnancies— especially during the later stage of married life—were still considered an expression of female sexual desire and therefore a matter of shame and dishonour for the woman concerned. The following narration of a 45-year-old pregnant woman illustrates how women's status within the family defines women's 'choice' and need for abortion.

> I have not had a family planning operation. I delivered five children and after every delivery the doctor would advise me to have the operation. But I never went for it. Only now I am feeling ashamed about the continuous pregnancy because my husband's first wife's daughter is also pregnant and she already has another child. Instead of being a grandmother, I am also delivering babies along with her. I tried to abort twice but I did not go to the

hospital. I tried all the local methods: ate papaya and drank gingili water. Nothing happened. Then I took an injection from a local doctor. By then it was too late. Some women have abortion even in the fifth month. But my foetus was very strong. People here make fun of me and they say I have too much of sexual desire. It is embarrassing for me. That is why I went for abortion. I do not mind having children. What harm have they done?

In contrast, the younger generation of married women seem to be using abortion as a spacing method, not merely because the state has popularised it but also because of the change that has come about in the notions of shame and honour, partly due to the state's agenda of population control. For the younger generation, it is not frequent pregnancy as an expression of excessive female desire but frequent childbirth alone, especially at the later stage of women's lives, that has become associated with the notion of shame. Therefore, a married woman can now talk openly about her frequent pregnancies and her desire to abort for the sake of a limited family without feeling ashamed of her sexuality. Honour is now associated with an early marriage and limited but successive childbirths (even if there are frequent pregnancies, the use of abortion as a spacing method is considered normal) immediately after the marriage. No doubt, the availability of abortion services along with sterilisation in hospitals has enabled women to assimilate the family planning logic into what they consider as reasons for seeking abortion. However, even within this logic of fertility control, how women reason out their choice of abortion and what other factors are involved in this decision are important issues that will be explored in the following sections.

Beliefs, myths and abortion

Women's decision to abort is often a process of accommodating the pressures of cultural values and beliefs. Therefore, abortion as a felt need grows out of prevailing cultural constraints as a means for negotiating social reality. For instance, in the study villages, almost all the women were very clear that induced abortion is inevitable if a woman conceives in the Tamil month of *Adi*, which is considered bad for the mother as well as for the maternal uncle of the child. If they conceive in this month, young married women opt for abortion even if it is their first conception. This belief in the ill effects of having sex and conceiving in the month of *Adi* can be seen from the testimony given by a 23-year-old married woman:

> They say consuming papaya leads to abortion. So, to abort the second child, I had papaya very regularly but nothing happened. I did not want to go to the hospital, as I felt they might advise me to go in for sterilisation. Even for the first child, I tried to abort it because I conceived in the month of *Adi*, which is not acceptable. Newly married couples are not allowed to sleep together (have sex) in that month. It is even worse if you conceive in that month. Therefore, I was desperate to get rid of the foetus. My mother gave me jaggery with gingili seeds. Unfortunately, nothing happened. Even now, my in-laws curse me for having conceived during the month of *Adi*.

Consulting the local priest (*samiyar*) or persons who are 'possessed' seems to be quite a normal practice among women in the study villages. Women take the risk of aborting the foetus in the second trimester or even later if the priest warns them about a possible threat from the newborn child to the family men. A 21-year-old married woman told us about how, following the advice of a priest, she was forced to abort:

> When my first child was just one-and-a-half months old and I was still breast-feeding him, I conceived again. I wanted to abort the second child and tried to do so with the help of some tablets purchased from a chemist. When this did not work, I gave up. At that time my husband and my mother-in-law were against the abortion. So I did not tell them about my efforts to get rid of the foetus. During the seventh month of pregnancy, I developed high blood pressure. My husband and my mother-in-law took me to the local priest who advised me to abort the baby immediately. He felt that the baby was possessed by a ghost and that it could harm the male members of the family. So my husband insisted on the abortion. You might not believe this, but the abortion took place automatically. When we reached the hospital the baby was found dead in the womb.

Similarly, women go back on their decision to abort because they have been advised to do so by a 'possessed' person, especially if the latter predicts that the child is of the male sex. As a 25-year-old woman told us:

> When I conceived my third child, I did not want to have it. So I went to a local doctor and got some tablets for abortion. I consumed a lot of them. In the meanwhile, I

> also approached a woman in the village who was said to be possessed (*Sami Adi*) and asked her what I should do about this child. As you know, we respect the words of possessed persons as they voice God's opinion. 'The god' told me that I should not abort the child since it was male. That very day I stopped taking abortion tablets. I did deliver a male child.

Like elsewhere in the country, preference for male children and therefore sex selective abortions are quite common in the study villages. Yet the women here do not avail of the new technology for detecting the sex of the foetus.[15] Instead, they prefer to rely on local methods, which are largely myth-based. For instance, women in the four study villages stated that they always looked for circular marks on their girl child's bottom (one near the anus and one above that). If there are two circles, then the next child is bound to be a girl! Even though some of the women admitted that their own experience had proved the belief to be false, most seem to be guided by it when taking the decision to abort. The doctors in private clinics confirmed the existence of this local belief and its role in abortion. For instance, a doctor from a popular abortion clinic informed us that most of her clients ask for abortion based on their observation of circular marks on the girl child:

> Most women who seek abortion complain to me about the problem of having girl children frequently. They do not want a girl child, especially if the first one is already a girl. Usually they guess the sex of the second child by looking at the girl child's bottom. If she has more than one circle or curve, then the second child is bound to be a female. I do believe in it. It is only in a few instances that this belief has failed.

In many cases, preference for a son has been the deciding factor for abortion. Women prefer to undergo sterilisation only after a male child is born. If there is already a male child, they do not hesitate in aborting the second child even if its sex has been 'predicted' as male. This is especially the case if the first one is still at the nursing stage. As many of the women informed us, it is to provide special care and attention to the first male child that they opt for abortion.[16]

Decision-making vis-à-vis abortion

Respondents listed domestic violence related to alcoholism and suspicion about female sexuality as the most common reasons for opting to abort. In other words, married women often perceived abortion as a means for negotiating domestic violence. For instance, a 35-year-old married woman stated:

> My husband is a drunkard and does not bring any money home. He just loves to sleep with me (have sex). After I conceive, he ignores me or physically abuses me. Or he pretends to be concentrating on some work. When the child is born, he denies paternity by saying that he is not the 'real' father. Since I have experienced all this twice, I decided to go for an abortion. There is no other way I could have handled the situation. In any case, when they (the children) are born I have to provide them with food while he goes around disclaiming his fatherhood.

Similarly, while narrating her experience of abortion, a 38-year-old woman told us how happy and relaxed she felt after aborting her fourth pregnancy:

> After three girl children when I conceived again, I was afraid that this might also be a girl. Even that did not bother me as much as my husband's obscene remarks about my sexuality. For this reason, every time I got pregnant I tried to commit suicide. But this time I decided to abort the foetus. But the doctor advised me against an abortion, as it was too late to have it. So I threatened the doctor, saying that I would commit suicide right inside the hospital if she did not perform the abortion. Only then did she agree to abort the foetus, which turned out to be a male child. Still, I was happy with the abortion, as this time my husband could not suspect the child and me.

As we can see from these narrations, while the act of abortion does reflect women's self-determination to deal with specific oppressive conditions, it does not necessarily indicate women's freedom of choice. In the study villages, often the onus for child care and supporting the family is exclusively on the women and abortion is one way to cope with the situation. The choice to abort is also related to their perception that sterilisation weakens the body whereas abortion does not lead to any health problems. For instance, explaining why she decided on abortion instead of sterilisation, a 27-year-old married woman, who works in a pharmaceutical company, said:

> I have not had sterilisation since I am afraid that it might affect my health and stop me from working. I do not have anyone to take care of the family economy.

> Therefore, after the first daughter, I went in for abortion twice. That did not harm me. I had to go in for abortions since I do not have anyone to look after the baby and I have to work since he has no job. The only way I can avoid frequent abortion is by avoiding sexual relationship with him. For the past six years I have been able do that. All this is because I have to work.

Similarly, a 29-year-old married woman, who also works in one of the companies, stated that she consciously made the decision to abort twice because she is the main earner in the family:

> I have been working in the company for the past thirteen years. My husband is a coolie with no regular income. After the first two children, I have had two abortions. Only three years back, along with the second abortion, I had the family planning operation. I did not feel bad about having abortions and there has been no health problem after that. I took about a week's rest after the abortions and got back to work. There is no one to take care of the children at home and if I do not work, my family will starve.

Thus it is clear that women without power exercise their choice to abort only under restrictive social and material conditions. However, though opting for abortion rather than sterilisation seems to be a conscious choice that women make, this choice is entangled with several other issues that need further exploration. For example, even as they choose abortion as a method of fertility control, they seem to resist the idea of 'family planning'.[17] Similarly, despite the availability of good abortion facilities in the government hospital, women seem reluctant to use them, mainly because of the aggressive attitude of the medical personnel working there.

Explaining why she chose to have her abortion in a private clinic, a 25-year-old woman stated:

> I went to a private clinic at Mahapalipuram for the abortion of my second pregnancy. They charged me Rs 1,000. I refused to go to the government hospital at Chengalpattu because there too they demand this much of money through various means. They force us to have sterilisation or use some contraceptives after the abortion. Only if we agree to this do they consent to perform the abortion. Many women do not go there precisely because of these conditions.

Women in all the study villages consistently and vehemently argued against availing abortion facilities at government hospitals. Not only are they against making availability of abortion services contingent on sterilisation, they also strongly resent the disrespectful, inhumane and abusive treatment meted out to them by the medical personnel, whom they accuse of being caste and gender-biased. Voicing concern about the abusive treatment married women receive in government hospitals, a 36-year-old woman remarked:

> When we go to the hospital for delivery, we are not allowed to express our pain. The doctors not only scold us but also pass rude remarks about our body and about our pregnancy. They shout at us, saying, 'You could enjoy sex and not feel the pain of penetration but come here and scream about pain.' If we ask for abortion, they say things like: 'You can lift your legs for your husband (i.e. you enjoy sex) without saying no and now you want an abortion.'

The women's narratives clearly and quite eloquently establish not only the alienating and insensitive nature of the medical services available, but also awareness of their reproductive entitlements, such as their right to abortion without the imposition of any conditions or abuse of their sexuality. However, the desire to have non-coercive, humane medical services does not mean that women totally boycott government hospitals that force them into 'family planning'. In fact, many young married women, who cannot afford costly private clinics, continue to use the abortion facilities offered by government hospitals.

The burden of our argument so far has been that despite the state's promotion of abortion as a method of family limitation, women have not just 'substituted' it for contraception but have consciously sought abortion for various other reasons. Women's decision to abort seems to be linked to various factors like responsibility for child care, marital conflicts, son preference, astrological beliefs and opposition to the sexual morality imposed upon them by the medical world. Since women do not have control over these social conditions, their 'choice' of abortion is basically to deal with these situations. Though the logic of family limitation through abortion as promoted by the state population policy might be influencing women's consciousness on abortion, how they arrive at the decision to abort is based less

on received notions of family planning or birth control than on certain social and cultural conditions and relations that define their lives.

Women, Work and Abortion

Women and work

In this section we discuss in detail the production process, the conditions of work and the work culture that operates in the pharmaceutical companies. This enables us to understand how a particular form of production relation and its associated work culture produces a specific socialisation process among working women, especially young unmarried girls. By mapping the work culture and conditions of work as perceived by women themselves, we attempt to unravel the complex relation between women's work and women's sense of 'reproductive entitlement'.[18] In other words, we analyse how the social relations of reproduction of young unmarried women are shaped by the culture and conditions of their work and how women who work in the pharmaceutical companies negotiate the harsh realities of work through their relations of reproduction, which include their practice of abortion.

Women as workers

As noted earlier, pharmaceutical companies recruit young unmarried girls in large numbers along with a few young married women. They are mostly employed as contract labourers. Some companies recruit only unmarried young girls, who are dismissed as soon as they get married. Explaining why they recruit only unmarried girls, the secretary of the pharmaceutical companies' association said:

> Only young unmarried girls without any family responsibilities can spend so many hours at the company. Young women are physically better fit for arduous work. They lose their physical strength and energy once they get married and have children. We cannot afford to give them maternity or sick leave. Moreover, what we care about is efficiency and concentration at work, for which we train them. In any case they are like machines with little brains. So if you mould them at a young age, they become as efficient as machines and work for as many hours as we want them to work.

The observation of a 22-year-old woman worker about how women are perceived within these companies corroborates the secretary's comments:

> Our company prefers only unmarried girls and makes them work like machines. In fact, women workers are often referred to as machines.

Another young girl of 18, who also works in one of these companies, remarked:

> We are no doubt treated like machines since we are not allowed to talk to each other and expected to work like machines from morning to evening.

Commenting on the company's demand for unmarried women, a 20-year-old young woman said:

> Today a boy and his parents had come to fix a marriage alliance with me, but I refused as I will be dismissed from work the moment I get married. Then who will look after my family?

The few men in these units are employed either as supervisors, chemists or machine operators. The companies seem to deliberately avoid recruiting men from nearby villages, as they do not want to risk any collective opposition or protest against their work culture. For instance, in a discussion with elderly women in the village located right behind the companies, a 60-year-old woman noted:

> There is not a single man from this village recruited for company work. They are afraid if the men come to know of how the girls are exploited, they might mobilise the entire village to uproot the companies from here. That is why you see the young fellows here, though quite well educated and willing to work in the companies, roaming the streets without any jobs.

Almost all the companies recruit young girls from the age of 13 and they are made to work from 8.30 am to 5.30 pm, with just a half hour's break for lunch. The salary is paid either as daily wage ranging from Rs 18 to Rs 30, or as monthly wage of up to Rs 1,500. Overtime work, which is usually an extra two to three hours, usually fetches the girls an additional Rs 2 to Rs 4 per hour, though some units pay an hourly rate of up to Rs 10. As many of the girls have to commute to work, the companies deduct van and tea charges from their salaries, which leaves them with only Rs 600 to Rs 800 per month. In order to save the money that would be spent on commuting, many girls, even from far-off villages, prefer to walk to work. Given their poor economic condition due to non-availability of agricultural work or other forms

of employment for the men in the family, most parents send their daughters to work in these companies despite the meagre salaries they receive. As one 14-year-old worker remarked:

> I myself went to work at the age of 13. In this village, almost everybody stops sending their daughters to school and sends them to work instead. The school headmaster here went from house to house to plead with the parents to send their children to school. He is the one who told us that it is illegal to send girls below 18 years to work. But who will listen to him?

The units are very strict about timings and if workers are late even by a few minutes, their day's salary is cut. Most companies do not give their workers medical coverage, despite the fact that the working conditions in these units place the workers in close proximity to various chemical-related health hazards. As a 28-year-old married working woman noted:

> They (the companies) are not bothered to give us medical allowance or meet the medical expenses. Three months ago, a young girl in our company met with an accident while operating a machine. It was a major accident as her hand got caught in the machine and was mutilated. Her medical expenses amounted to something like Rs 5,000, but they paid her just one month's salary and instead of giving her medical leave or even leave without salary, they dismissed her from work stating that she could no longer work with a maimed hand.

Very few companies offer an annual bonus; in fact, in most companies contract workers are denied bonus. The usual tactic used is to dismiss the contract labourers just before bonus is given. Some companies routinely offer workers six-month contracts, which are then renewed after a break in order to avoid making the jobs permanent. The testimony of a 27-year-old woman employee effectively sums up the working status of most women in these companies:

> I joined this company seven years ago at a salary of Rs 15 per day. Till now they have not made me permanent. In these seven years, they have given me several breaks. I am afraid if I make this into an issue, they might give me a break and not take me back. Even if I question why I am paid so little, they will throw me out. They have not allotted me any provident fund (PF) and there is no medical allowance. Sometimes they ask us to do overtime work and pay us just Rs 2 per hour. There are 30 ladies working here and only three of them have been made permanent and two among them are married women.

The companies seem to follow an arbitrary employment policy, offering permanent jobs and other benefits to some but denying them to others, even if they have been working in the company for many years. A 28-year-old married woman, who has been working in one of these units for eight years, commented:

> I have been working in this particular company for the past eight years and before this I worked in another company for two-and-a-half years. I am doing all the work that they require me to do: right from bottle-washing to lifting heavy cartons. But they have not made me permanent, nor have they made any provision for a PF. But a girl who is known to be having an affair with a supervisor has been made permanent despite the fact that her fingers got twisted in the lab and she is hardly able to do any work.

Even having a permanent status does not empower the employee to bargain for a better salary or better working conditions or even medical benefits. It merely ensures job continuity. As a 34-year-old permanent employee of one company stated:

> In this company even those who are permanent employees do not raise the issue of low salaries, although they participate in the meetings with the employers. In these meetings, only issues relating to increase in production, efficiency of the labourers and how to meet the competition from other companies are talked about. There is never a word about labour welfare or discussion about workers' benefits.

The production process

Women workers in pharmaceutical companies are engaged in a variety of work, which can be broadly identified as batch-taking, mixing, liquid or powder-filling, blister-packing, strip-packing, bottle-washing and packing, fixing of labels and loading and stacking medicine-filled cartons.[19] Jobs like mixing the ingredients specified by chemists for the preparation of the drugs, sieving the powder as well as broken pieces of capsules and tablets, filling them into or packing them as strips, filling liquids into bottles and bottle-washing are all done exclusively by women workers. As soon as they

enter the company, the supervisors divide them into various groups and allot each group specific tasks for the day. Each worker in the group has to complete the target set for her, otherwise she is bound to lose her job.

Usually, illiterate women workers and new entrants are assigned to wash bottles, which is a very demanding and backbreaking job. A 17-year-old girl, who has now left the company, described the work of washing bottles thus:

> When my cousin and I joined this company, we were given the job of washing bottles. It was only later on, after looking at my educational qualifications, that they shifted me to another section. Bottle-washing is a horrible job. We have to lift thousands of bottles in a sack, carry them to the wash area without breaking them and then wash them all. It takes the entire day and sometimes even more than the usual working hours to wash, dry and dump them in the packing section. My cousin used to complain of itching and blisters on her hand and I myself once sustained a serious injury due to a broken glass bottle. Other women in our section used to complain of continuous backache since we had to crouch on the floor for long hours.

Other women complained about the unreasonable targets set for filling tablets and liquids and for packing the filled bottles in boxes. They also complained about how they have to keep pace with the machines, especially in the packaging section. However, most women regard these jobs as considerably less demanding when compared to the lifting and loading of heavy boxes, which also has targets. We can gauge the conditions and nature of work in these companies from the description an 18-year-old girl gave of her work experience:

> I do jobs like fixing of labels, packing and lifting and loading heavy cartons. Only women do these jobs. The men are there, but they do not lift weights. We also have to load and unload sacks of sugar sacks and other heavy boxes from the van. They must weigh at least 100 kg each, and four women are needed to lift each box. So many of them have to be loaded and unloaded per day. . . . They have a target for each day. If we cannot meet the target, they abuse us saying: 'You do not have any brain, you are useless,' etc. Even the liquid tank has to be cleaned only by women. If we do not wash that properly, they ask us if we are eating shit or food, and make us wash them repeatedly. The men only run the machines. If there is no machine work to be done, they sit around and chat and laugh. Nobody questions them or controls them. Only we are scolded for everything. Women suffer so much in these companies.

Another 27-year-old woman noted how women are discriminated against and how the work is physically very demanding:

> Women are made to do all the hard work, which is physically impossible for women to do, whereas men are only asked to operate the machines. Women are even made to lift the goods and load them on the lorries. There is also a target for loading heavy boxes on the van. We load nearly a lakh of boxes on the van, sometimes even more, depending on the completion of the product.

Conditions of work: regulating female sexuality

It is not just the targets, heavy workload and health hazards that swamp the women workers. Any lapse on their part leads not only to dismissal but also physical and sexual abuse by male supervisors and chemists, especially of young unmarried girls. Describing the attitude of the supervisors, a 17-year-old girl said:

> The supervisors always dominate us. We are not supposed to question them. We are not allowed to take rest but have to work continuously, without any break and without showing our tiredness. If we are slow or if we appear to be sluggish, they abuse us, using terms like 'street dogs', 'lazy bums', 'wasteland' or 'dirty pigs'; sometimes they ask us if we are eating food or shit. They always address us as brainless ones, machines and lazy bums. Earlier, when we made even a minor error, they hit us on our heads. This has stopped now, as it led to some serious incidents of injuries.

The power of the chemists and supervisors invariably expresses itself in the sexual abuse of young unmarried girls and in regulating female sexuality in general. While narrating her encounters with chemists and supervisors, a 27-year-old married woman noted:

> We have never seen the owner or the director of the company. Only the chemists scold us and order us around every time we are a little slow with our work. I have often had altercations with the supervisors as they abuse us in bad language. I was bold enough to question them. There was a supervisor from Thirunelveli who used to misbehave with the girls and even sexually abuse

them. I seriously objected to his behaviour, as did many other girls. When the management finally sensed our objections, they removed him from the job. Not that they were concerned about us. They felt he was disruptive and girls could not work because of him.

For many young unmarried girls, fulfilling the sexual demands of supervisors and chemists seemed to be the only way of escaping physical and verbal abuse and easing their harsh working conditions. A 23-year-old unmarried girl described how the supervisors in her company favour young unmarried girls who give in to their sexual demands:

> They (the supervisors) do not value work experience. Even new recruits, if able to entice the supervisor, get paid well without having to do much work. Because it is he who decides the quantity and quality of work that each worker has to put in. No one, including the manager, questions the authority of the supervisor. . . . One supervisor of our company only employs girls who attract him and he is well known for dismissing those who do not fulfil his desires. We are afraid of him. Only the married women have the guts to speak to him. This is the reason why I am losing interest in the work.

Similarly, another 37-year-old woman talked about how sexual exploitation by supervisors was rampant in her company and what it has done to women workers:

> In our company, a young supervisor has a sexual relationship with an elder woman and he purposely overlooks the mistakes she makes. Now he has given employment to the lady's daughter. This lady goes to the extent of purchasing vegetables, etc., for him from her salary. Almost all the supervisors in this company are like that and there is no exception. Another girl in our company was seduced and raped by a supervisor. But she was under the illusion that he would marry her. He refused and even denied having sexual relations with her. She had to undergo an abortion and she is very sick. Now she refuses to marry anybody and has also left the job.

Given the enormous power and authority vested in the supervisors, even in cases of rape and sexual exploitation that come to the notice of the management, it is the girls who are punished and risk losing their job if the issue becomes public knowledge. A 25-year-old woman described how another woman worker in her company was victimised because her case of rape and abortion was much talked about within the company:

> In the case of S from our village, a supervisor raped her and she became pregnant. She took a few days' leave in order to have an abortion. When everybody in the company got to know about it, instead of dismissing the concerned supervisor, they dismissed S from work on the pretext that she had taken long leave. Nobody ever raised the issue of rape by the supervisor.

It is not only sexual exploitation by supervisors that affects young women workers, but also the rules and norms set by the companies to regulate female sexuality. For instance, in almost all the companies, except for the male supervisors, no woman worker is allowed to talk to any male worker. The supervisors are assigned the duty of monitoring the behaviour of women workers, especially the young unmarried ones. If they are found in violation of this rule, they are immediately dismissed. Breaking these rules can thus result in very severe repercussions for the women. As is evident even from the earlier narrations, the supervisors enjoy enormous powers and can easily manipulate the rules in their favour. The recounting by a woman worker of an incident that took place in a company gives us a sense of how these rules are misused by the supervisors.

> In our company, M, a fellow male worker, jokingly pulled a girl's coat to ask her to wash the tray. They know each other but there is no love affair between them or any such thing. On seeing this, the supervisor informed the manager who dismissed both of them from work. They tell us that male–female relationships always lead to wrongdoings. They have even displayed this rule on a board that has been placed at the entrance of the industry. Since the companies view male–female relationships as causing unnecessary interference in work, monitoring young girls' behaviour with men has become as essential as monitoring their efficiency in work.

Speaking about her company, a 20-year-old unmarried worker said:

> There is a general rule in the company that women and men should not talk to each other. There are three supervisors just to monitor our behaviour. Even in the extreme situation of an accident, fellow workers are not allowed to talk to each other. They are very strict about love affairs between the workers. If they get to know

about it, they dismiss the woman worker at once. If there is a love marriage between the workers, they allow the boy to continue working but dismiss the girl. At the time of recruitment, they always advise us against love affairs. If some workers share a friendship, they deliberately separate them by placing them in different work groups.

Some companies regulate the clothes that women workers wear. Further, they monitor their social activity, even if occurring outside the company. As a 19-year-old unmarried girl who works in a reputed company commented:

> They are strict like in schools. We are allowed to wear only half-saris and not *churidars*. We are not allowed to wear bangles or flowers. They keep on advising us about how to be disciplined. Through some reliable people, we have learned that they are monitoring us even outside the company. If we violate these rules, we can lose our jobs. They do not give us enough time for lunch or tea. So we do not find time to chat. These companies control us just as our families do.

As noted earlier, other than regulating the social life of their workers, some companies strictly prohibit the entry of married women into their workforce. Those that do employ married women, dismiss them as soon they come to know that they are pregnant. In this context, it is important to analyse how women workers, especially the young unmarried ones, negotiate these conditions at work. For it is in resisting and negotiating the work conditions that unmarried women workers seem have exercised their 'choice' in reproductive control.

Negotiating work and sexuality

For many young unmarried women, there is no escape from harsh working conditions as they are forced to earn an income for their families. Often, they are the sole breadwinners. They cannot, therefore, afford to leave their jobs. Instead they are compelled to negotiate the conditions of their place of work. The following narration by an 18-year-old girl effectively sums up the dilemma and tensions that unmarried girls share about the workplace and earning their livelihood:

> Only we are scolded for everything. Women suffer so much in these companies. The money they (the companies) give (Rs 600) is not enough to even pay for our daily meals. I give the entire money to my mother and she takes care of our needs. We have no option and so we are working in these wretched companies. I don't like to work in the company but my parents will not let me leave. They scold me if I do not go there. If I go there, the supervisors scold me for little things. I cannot escape this daily ordeal. If you were not sitting with me to chat, I would be made to fetch water and do household work too. My sister, who goes to school, is not allowed to do any household work. I am burdened with company work and household work. Even when I want to, I cannot take rest after the long day's work. My parents compel me to work in the company. I do not like either of the places. They are not arranging my marriage, as there is no money. I do not know what I am going to do.

Similarly, another young unmarried woman worker noted:

> I know I am unable to cope with the workload and the strict rules of the company, but how can we survive without any work? Since we have no other option, we try and find our own ways of enjoying life.

Unlike these two workers, some young girls felt that working in the company enables them to escape household work and also the family's control over their mobility. For instance, a 17-year-old girl said:

> We do not feel so great working in the company. But the company is better because, unlike our mothers, we do not have to toil under the sun. Besides, I like going out to work since I can dress up well. If I were at home I would not have been allowed to dress up like this.

However, most of them felt that the rules set by the companies favour only the supervisors and work against the interest of the workers. The reaction of an 18-year-old girl illustrates their desire for breaking rules:

> We slog in the company like cattle and they treat us like machines. Why should only the supervisors have fun? We are not asking for any facilities or allowances, but why should we not be allowed to socialise with our fellow workers?

Many of them boasted about how they violate some of these rules. A woman worker said that since her company is very strict about male–female socialisation inside the workplace, the girls speak to the men through masks which are given to them as protective gear. The supervisors cannot make out whether they are speaking

to each other or to the men. The women also use sign language to communicate and, during lunchtime, tease each other about their affairs. A 17-year-old mentioned that since her company employs only unmarried girls, those working with her have lovers but do not get married to them immediately as they are likely to lose their jobs after marriage. A 28-year-old married woman commented on how unmarried girls utilise the few minutes of break from work:

> A major pastime of unmarried girls in the company is to talk about love affairs. The 10-minute break we get for tea is spent by them in talking about their partners. They even forego their tea for the sake of chatting. Only married women like us consume tea.

Narrating how unmarried girls violate company norms, a middle-aged woman observed:

> When I worked in the company, many young girls used to have love affairs. The company people did not get to know of this, as the girls would deliberately choose to form relationships only with men of other companies. They would spend time with each other on the way to work and while returning home. Some of them got married, but most of them were deserted.

Even married women violate the rules and norms that regulate their sexuality. For instance, a young married woman told us how, in order to get work for a few months, she violated the company norms:

> When I sought a job in one of these companies, I did not reveal that I was married or that I was pregnant. My husband also worked in the same company but they did not know about this. Co-workers always help each other in these matters. Be it a love affair or pregnancy, they will not talk about it to the managers or supervisors. Since they gave me an apron and a thick coat, I could hide my bulging stomach. Even though we girls know how strict the management is about marriage and pregnancy, we constantly defy these rules. Otherwise we won't be able to earn any income. Of course, despite our condition, we had to lift heavy weights and do all the jobs required of us. If we didn't, we would lose the job.

Violation of rules by married/pregnant women does involve health risks, but it is the only way they can get around the rigid rules of the company. In addition to breaking rules relating to socialisation, many young girls seem to negotiate the burden of their work by allowing their sexuality to be regulated.[20] Explaining how this takes place, an 18-year-old girl stated:

> All this does not take place inside the company as they are very strict about rules and we can't even talk to any men. But the girls and supervisors or chemists fix their meetings elsewhere and even stay out. We know of many such cases. All of them don't get married. In fact, we know of no instance where a marriage has taken place between a supervisor and any girl who works there. Abortion is bound to take place. We know about it. What else we can do? Not that all girls do this kind of thing. Supervisors are the main culprits and they should be blamed for all this.

Even though the majority of women feel that supervisors sexually exploit unmarried women, some think that working girls negotiate their unequal relationship in the workplace through sexual involvement with supervisors and managers, and it is they who use private clinics for abortions. Narrating the case of a young girl who had recently undergone an abortion, a 19-year-old fellow worker from the same village observed:

> She comes from a poor family and her family is dependent on her salary. She is involved with a supervisor who is married and has no intention of marrying her. She has had at least two abortions. The benefit that she gets for all this is that she has been made a permanent employee. She has even taken one month's leave, which none of us would be allowed to do. She does not put in that much of work because of her sexual contact with the supervisor.

Assessing the activities and attitudes of young girls towards work and sexuality, an 18-year-old girl said:

> There are some girls who are bold enough to have relationships with men. They can even have sexual relationships without worrying about marriage. They will continue to work. Some, like K, commit suicide. I know a few girls who have taken their friends and gone to a clinic for an abortion. This is the sort of price one pays for earning money. Some may consider all this as one of the hazards of working in the company; but the girls enjoy their work and also their love life.

Unmarried Working Women and Abortion

There are two aspects that are clearly discernible in our discussion on women's work and the regulation of their

sexuality. One is the compliance of young unmarried girls in sexual relationships with/sexual exploitation by their male superiors in order to negotiate their harsh working conditions. The other is their engagement in sexual relationships as a way of resisting the regulation of their sexuality by the companies and protesting against the increasing restrictions placed upon them by their families. As some of the narratives show, abortion emerges as an important indicator of both these trends (compliance and/or resistance). Their experience of abortion is also mediated by the notions of sexuality that prevail within their families, especially in the context of their enhanced status as wage-earners and providers for the family. In this section we analyse the incidence of abortion among unmarried working girls to show how it is linked to women's work, social status and sense of sexuality and reproductive control. Since we could not obtain personal narratives from them, our analysis is based on interviews with doctors and women of different age groups, especially their perceptions of abortion among unmarried working women.

Almost all those we interviewed, including the working women, said that there has been an increase in the rate of abortion among unmarried girls after they started working for the companies.[21] According to two doctors from private clinics located at a 5-km distance from the companies, about six to seven unmarried working girls, employed mainly in the pharmaceutical companies, seek abortion services in their clinics every month.[22] A doctor who runs a clinic in Mahapalipuram said:

> I started this clinic nine years ago. From that time I have seen an increase in the number of young unmarried girls coming for abortion. Mainly, it is the girls working in the pharmaceutical companies who come to me for abortion. Many of them are from one particular village located very close to this clinic. They are mostly in the age group of 17–18 years and they come with their mothers or with their friends. Some come with their partners.

Similarly, a doctor in a private clinic at Thiruporur stated that the girls who come to her for abortions are mostly in the age group of 18–22 and an overwhelming number of them are unmarried. She also observed that before the establishment of the companies, there used to be hardly two or three cases of abortion among unmarried girls. This number has now increased to about ten a month. An unregistered doctor, who is well known for her abortion services and runs a private clinic located at a distance of 15 km from the companies, noted:

> Earlier, very few unmarried girls, mainly agricultural labourers, used to come to me for abortion after being raped by either the landowners or the upper-caste men of the village. In recent years, however, a lot of young unmarried girls—mostly in the age group of 18–22—employed by the companies have started coming to me for abortion. I don't keep a record of all those who have come here, but I recognise them when they come next.

Commenting on how abortion among unmarried girls who work in the companies has become common in her village, a 35-year-old woman remarked somewhat exaggeratedly:

> They (young unmarried girls) go to work in the morning and in the evening they are having abortion. This is the rate at which it is happening. . . . Take the case of K in our village. She has undergone abortion at least three times and she is just 20 years old. We all know about it.

Another 27-year-old woman worker described the case of a fellow worker to illustrate how unmarried working girls have come to perceive the practice of abortion as normal and acceptable:

> In our company there is a girl called S who has had two abortions. She had the second one about eight months ago. Now she is again pregnant for the third time. She has now left her job. I hope she doesn't undergo abortion again, as she is only 17 years old. When she conceived the first time, she was working. She would run to the terrace of our company and vomit there. One day I noticed this and asked her about it. She took the next two days off and had an abortion. When she returned she was very normal and continued doing all the work as before. I am saying all this to tell you that this is nothing new or unusual for the women working here.

Family, Sexuality and the Secrecy of Abortion

As has been elaborated in the first part of this report, with a large number of young unmarried girls being pushed to work in the informal industrial sector, combined with the demand for dowry and lack of employment for young men, new forms of control over female sexuality have emerged within the family. Simultaneously, there has also emerged resistance to these new forms of control—resistance that is visible in the attempt by unmarried working women to regulate their

sexuality. In other words, the changing social conditions are also enabling working girls to rework their strategies and sense of reproductive entitlements within the restrictions imposed by their families and the companies they work in. During an FGD, one elderly woman said:

> Earlier, the caste panchayat would be called to discuss love affairs. They either separated the lovers or ordered their wedding. If a girl became pregnant, she was allowed to deliver the baby and the girl's family looked after both of them until they found a boy for her marriage. There was no taboo attached to those who gave birth to a child before marriage. There was community support even for those who made the mistake. Nowadays, girls are not afraid of their parents. They themselves decide on their marriage. Because even if the mother agrees to the wedding, either the brother or the father creates problems. So the girls run away and get married. What can one do about it? The girl's brother or uncle keeps a vigil over her when she goes out to work, especially if she is travelling by bus. To escape this, the girl goes to some secret place with her lover, and if anything happens, she goes straight to the clinic (for an abortion). Now where is the need for the panchayat? In any case, panchayat decisions are not binding on these people, as the lovers of these girls are from outside the village.

It is not only surveillance by men but also the new social norms that have emerged within *dalit* families that force young girls to work out their own strategies of reproductive control. As one middle-aged woman observed:

> Dowry is a problem that forces the girls to go haywire. Even if the boy is uneducated and unemployed, he is demanding a lot of things. At least a lakh of rupees is required to get married. In the company, girls are employed only for six months. The boys from this village do not find any job there. There are many boys from outside and all the affairs are with them only. The girls submit themselves to outsiders who are educated and dressed well.

While discussing how young unmarried girls working in the companies use various strategies to negotiate social norms, a 20-year-old working girl observed:

> The girls who go to the company work very hard and at the same time manage to roam around with their boyfriends. At home, they say they are doing overtime work and then push off somewhere else to have fun. Usually, the parents do not know anything about the salary scale. They accept whatever the girl brings home, as they are in need of money. A lot of girls from my village have had abortions and everybody knows about it.

It is clear from this observation that poor *dalit* families have become dependent on the earnings of young unmarried girls. In a sense, this authorises, if not empowers, the latter to make reproductive decisions. The self-assertion of unmarried girls on reproductive and sexual matters becomes very obvious when we consider their knowledge of reproductive matters and the decisions they make relating to abortion. Commenting on how young unmarried girls in her village handle the situation of abortion, a 21-year-old working girl said:

> I have been working in the company for the past three years and I know exactly how the girls deal with issues like abortion. They are very secretive about these things. If we sense something and ask them about it, the girls do not tell the truth but make out that they have a fever or body-ache or some such illness. They go for an abortion either with their mothers or their partners. After two days, they resume work as though nothing has happened. The girls know everything about abortion and where to get it done. The mothers or partners just accompany her.

In the same vein, a birth attendant from one of the study villages remarked:

> These days, if unmarried girls have any problem with their lovers, the first thing they do is to get an abortion. They don't mind if they have to spend more than what they earn to do this. After all it is their decision.

Knowledge about pregnancy and abortion is thus widely prevalent among unmarried girls, yet they have virtually no knowledge about contraception and contraceptive methods. During our interviews, most of them feigned ignorance about contraception but acknowledged that they know what abortion is and why it is done. They could not, however, describe the methods used for abortion. Many of them also said that they do not see abortion as a sin or mistake; rather, they consider it to be an inevitable part of sexual relations. The doctors from private clinics whom we interviewed corroborated

this finding. One of them, who works in a private clinic in Thiruporur which is located very near to the estate, remarked:

> They (the unmarried girls) very rarely come to me for irregular menstruation or other reproductive problems. They know that they are pregnant and say as much. Then, very casually, they ask for an abortion. I have never noticed inhibition or reluctance in them when they ask for an abortion. It has become a matter-of-fact issue for them.

Similarly, another well-known gynaecologist from a private clinic in Mahapalipuram stated that abortion is no longer a moral issue for unmarried girls despite the notions of social dishonour and sexual immorality that are associated with their identity.

> Some girls who work in the companies have come to me for repeated abortions. This is not because they lack awareness about pregnancy and sexual relations but because they have no regret about having an abortion. They take it all very lightly, as if it were a natural part of their life. This is my feeling about them since I talk to them at length about these things.

However, even though unmarried girls now take this reproductive decision, i.e. abortion, themselves, it is a decision that is enmeshed within new forms of social control and values that were hitherto unknown to the *dalit* community. For instance, pregnancy and motherhood among unmarried girls is no longer acceptable; instead, family honour, and therefore the need for maintaining secrecy on issues like abortion, have become more important than even the girl's life. The following story about the death of girl due to abortion illustrates this point:

> Last year, a girl—K—in this village died after trying to abort her foetus. She was going around with a fellow from the company (he is a chemist) and conceived. When she was five months' pregnant, he promised to marry her and her family knew about this. But her mother insisted that she abort and forced her to consume some tablets.[23] Perhaps she took an overdose, but it resulted in her death. At the last minute they took her to the Chengalpattu hospital but she died there. The post-mortem revealed a five-month-old foetus. Since K was unmarried, it became important for her family to abort the foetus in order to save the family honour. Her sister too works in a company and if K had delivered the baby, she might have found it difficult to get a groom.

It is evident from this that unwanted pregnancy or abortion often occurs in the context of strengthening patriarchal values about sexuality even under the changing circumstances based on the young girls' identity as sole income-earners. It is the new cultural norms and patterns or, in other words, the new social relations that have emerged as a result of this that effectively control female sexuality and ultimately limit the 'choice' and 'free will' of women.

Explaining how in most cases abortion is a fall-out of the failure to contract marriages with 'outsiders', an 18-year-old working girl contended it is something that has to be kept secret since the girls are not in a position to negotiate the prevailing social values and hierarchies. She remarked:

> If a girl becomes pregnant (before marriage), no one questions the partners as they are from outside the village. Marriage might not be possible with that person. So they go with their parents to the abortion clinic. It is a secret matter. Very few in the village get to know about it. When the girls undergo abortion, they take leave for two days and get back to work without any problem. They usually tell the others that they were down with fever or headache or some such thing. In most cases, marriage does not take place either because of the caste or economic status of the boys, who might well be the bosses of the companies.

Since secrecy is important to those who undergo abortions, they have to be careful about choosing clinics or doctors who would not divulge details about them, particularly to persons who belong to the same community or village. Therefore, despite the exorbitant charges levied by private clinics,[24] girls prefer to use them in order to 'save the family honour'. Some of them explained why they do not avail government facilities:

> We would never go to a government hospital to have an abortion. Over there they misbehave even with married women who need an abortion. The doctors make obscene remarks about women's sexual behaviour. With unmarried women, they take even more liberties and scold and ridicule them. Even people in the village speak badly of these girls. That is why most of us go only to private clinics, where the doctors are more understanding and keep our visit a secret. All we need is money for

abortion. But even to the private doctors, the girls do not provide all the details. Abortion is not a problem. But if the girl happens to marry somebody else, he should not harass her due to past events.

We may conclude from the various narrations in this section that women's work in the informal sector, such as in the pharmaceutical industry, might have enhanced their status within the family as main income-earners or as providers, but it has not empowered them as decision-makers in the domain of reproduction and sexuality. In these circumstances, women's decision to abort does not signify their autonomy or free choice. However, in the specific context that we have so far described, the decision to abort by unmarried girls does emerge as an act of 'strategic accommodation'[25] or as a combination of both complicity and resistance.

CONCLUSION

As we have stated in the section on married women and abortion, using the quantitative data on the high prevalence of abortion rate among women in Tamilnadu, studies have concluded that women utilise abortion only as a birth spacing method. In our study villages, however, women across generations seem to reject the idea of abortion as a method of family limitation. This comes out clearly in their resistance to perceive abortion as a 'family planning method' and in their refusal to avail abortion along with sterilisation. On the contrary, women seem to view abortion as their reproductive entitlement: this is made explicit in their perception of abortion as a necessary tool to negotiate domestic violence and other oppressive social conditions. Their refusal to accept the disrespectful and sexually abusive abortion services offered by government hospitals clearly reflects women's assertion of their reproductive interests.

The attempt by young unmarried working girls is to use their sense of reproductive entitlement to negotiate harsh working conditions and the increasing control over their sexuality at the workplace and at home. But, as Rosalind Petchesky notes: 'Having a sense of entitlement may be very distant from the ability to act on it effectively' (Petchesky and Judd 2001: 317). While abortion by unmarried girls might signify subtle sexual and reproductive strategies or even a 'counter-hegemonic morality' to existing social conditions, it simultaneously also signifies women's lack of control over the oppressive conditions of work and other social realities (ibid.: 317).

What is significant about the escalating rate of abortion among unmarried young women is that it coincides with their increasing employment in the industrial sector.[26] The high incidence of abortion among them might appear as a conscious reproductive choice emerging from their role as providers in the family. Unfortunately, however, it is only a means for negotiating the disempowering conditions of their work and production relations. But this pattern is significant because it presents a striking contrast to its practice by married women, both young and old, whose knowledge and perception of abortion are shaped mainly by their agenda of fertility control and reproductive responsibility. Abortion among unmarried girls, especially in the context of our study, is largely associated with the increasing visibility of women's sexuality outside the family and their view that the circumstances leading to abortion are not of their own making. It has also got to do with the changed consciousness among young unmarried girls about their economic self-sufficiency (the fact that they have abortions in private clinics, which are quite expensive) and their association of abortion with normal reproductive conditions. To some extent, the legalisation of abortion, combined with the increasing control of their sexuality, has also contributed to this trend. However, this is not to say that there was no abortion among unmarried women before the legislation on abortion was passed. On the contrary, our claim is that in the past, when their monetary contributions to the family were insignificant and when their mobility was largely limited to just their village, unmarried women were denied the power to negotiate sexuality on their own terms. Besides, there was no stigma attached to unmarried motherhood, which was culturally acceptable.

As Upendra Baxi has argued, the unorganised sector is the 'constitutive place of violation' that not only denies labour rights but produces the material bases for the denial of reproductive rights (Baxi 2000). It forces women to choose between the latter and the need to earn a livelihood. Given this, we would argue that labour and reproductive interests are mutually inclusive and should form part of labour legislations as well as reproductive health policies. Therefore, the 'structural factors' that we talked about in the beginning of the report

need to be addressed when dealing with reproductive rights. For instance, in the absence of labour rights, such as the right to equal wages, enabling work conditions and right to unionise—all of which directly impinge on reproductive rights—liberal laws that encourage abortion and provide good abortion facilities might undermine women's reproductive rights.[27] This is because, as Baxi has argued, reproductive rights entail, among other things, respect for the right to reproductive self-determination and elimination of discrimination in conditions of work and in health care (Baxi 2002). Thus, for marginalised poor women to achieve reproductive rights would require changes not merely in the quality and availability of health services but also in the structural conditions and state policies that promote gender-biased economic and social systems.

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NOTES

1 The Medical Termination of Pregnancy Act, which was passed in 1971, legalised abortion by making abortion services available through registered doctors in government and private clinics. The Act came into force in 1972. For details on how abortion came to be legalised in India, see Jesani and Iyer (1993) and Menon (2002).

2 See Nagaraj (2000) and IPS (2001).

3 According to the NFHS data for 1992–93, the incidence of abortion in Tamil Nadu was 11.3 per cent and the all-India rate was 5.8 per cent.

4 The same trend could be noticed in 1992–93. As per the NFHS data for this period, spontaneous abortions accounted for 7.0 per cent compared to 4.5 per cent for all-India, while induced abortions in Tamil Nadu stood at 4.3 per cent as against the all-India rate of 1.3 per cent. Although our study has not dealt with the incidence of spontaneous abortion and its implication for women's reproductive rights, the high rate of spontaneous abortions in Tamil Nadu, especially in the age group of 15–19 years (17.5 per cent), points to the fact that abortion has a marked presence in fertility control in the state.

5 For detailed discussions on the increasing control over female sexuality as an effect of women's employment, see Anandhi, Jeyaranjan and Krishnan (2002).

6 I have borrowed this term from Upendra Baxi, who explains reproductive interest as one that involves reproductive security, reproductive sexuality, reproductive health, reproductive equality and reproductive decision-making. It could also connote any one of the above. See Baxi (2000).

7 For a general debate on reproductive rights, see Baxi (2000); for the debate on situating abortion in the context of rights, see Menon (2002).

8 For details on the economic transition of the district in general and women's employment in particular, see Jeyaranjan and Swaminathan (2001). The Chengalpattu district is now bifurcated into two districts: Thriuvallur and Kancheepuram. Our study villages come under Kancheepuram district.

9 While for 1981 and 1991 we have provided the census data for Chengalpattu district, for 2001 we have roughly calculated for the two districts (Thiruvallur and Kancheepuram) from provisional census tables; Census of India, Chennai (2001).

10 For details on the increase in industrial employment among women in 1999, see Jeyaranjan and Swaminathan (2001: 31).

11 Unpublished study carried out by RUWSEC.

[12] For the sake of anonymity we have used pseudonyms for the study villages. For the same reason, the names of the participants in the study have been withheld.

[13] The difficulties of bringing together young unmarried working girls for FGDs were manifold. First and foremost, given the nature of their work, which takes up most of their time, they were not available for discussions. Secondly, even on Sundays, when they were somewhat free, they had to seek their parents' or brothers' permission to come out of their house to chat about issues like sexuality and abortion—issues that unmarried young women are not expected to talk about in public. Thirdly, the precarious nature of their employment made them very apprehensive about openly discussing their work conditions, leave alone issues of sexual exploitation and sexual relations.

[14] By material assistance we do not mean monetary help but assistance to those women who seek help in approaching doctors for their reproductive health or even general health problems.

[15] One may note here that in Tamil Nadu, unlike in other parts of the country, preference for a male child plays an insignificant role in abortion. The *National Family Health Survey (1998–99)* indicates that 82 per cent of women who wanted a child said that the sex of the child does not matter and 46 per cent who wanted another child said the same thing. Only 9.6 per cent of women stated that they wanted more sons than daughters.

[16] This is not unique to Tamil Nadu or to the study villages. There are several studies that refer to this phenomenon. For instance, see, Ganatra (2000: 201).

[17] Women of all three generations across the study villages strongly opposed the forced sterilisation and the state's propaganda on family planning. The older women constantly recollected the target era of the 1970s, when their men too had to undergo vasectomies. They also mentioned how that memory of forced family planning has made them oppose even 'voluntary' family planning by women today. The middle-aged women spoke of the era of incentives, when men and women were not forced but lured by material benefits. They therefore viewed family planning as a welfare programme and, apart from the incentives it offered, did not consider family limitation as having much importance in their lives. Many of them were also critical of the programme as they felt that incentive-based sterilisation only brought more women under the fertility control programme but did not benefit them since the programme was implemented at the cost of women's health. Even the third generation of women, who are voluntarily opting for sterilisation, told us that abortion should not be linked to the idea of 'family planning'. According to them, since they undergo abortion not for family limitation but for other reasons, family planning (*kudumba kattupadu*) means only sterilisation, or what they call 'operation' and not abortion. Across generations, many women stated that sexual abstinence was their most common and frequently used form of contraception.

[18] I have borrowed this term from Petchesky who explains that the sense of entitlement is what women *feel* (emphasis mine) that they are permitted to or *feel* that they have a right to within a specific social context of norms and relationships which are also continuously changing and contested. In reality, this sense of entitlement, as she argues, may remain unrecognised and unfulfilled. See Petchesky and Judd (2001: 13).

[19] For details on the nature of work in pharmaceutical companies, see Jeyaranjan and Swaminathan (2001).

[20] It may be relevant here to cite Petschesky's analysis about teenage sexuality. She notes: 'For adolescents, sexuality, pregnancy, and abortion are densely mediated by agendas other than what they appear; they become the terrain for negotiating gender, child and adulthood, and gender-specific class and race' (Petschesky, op. cit.: 207).

[21] For details on different methods used for termination of pregnancy among unmarried girls, see Ganatra (2000).

[22] The increasing number of abortion seekers among young unmarried girls and the lack of authentic data are matters of grave concern to feminist scholars and activists. See, for instance, Ramachandran (1999).

[23] We consulted a private doctor to ascertain the possible cause of K's death. In the doctor's opinion, K's mother might have administered either a heavy dosage of anti-malarial tablets or RU 486. According to her, the latter could also cause death in a woman with low haemoglobin count (say, 7) along with the decision to have the abortion delayed.

[24] Usually the private clinics charge Rs 1,000 for an abortion in the first trimester and a further Rs 100 or Rs 200 for each month of pregnancy over the three-month period. The cost of abortion goes up depending on the month of pregnancy, especially for unmarried girls. This is an exorbitant rate considering the poor economic conditions of *dalit* families and the extremely low income of the industrial workers. In most cases, the girl herself or her parents have to meet the abortion expenses. A similar trend exists in other parts of the country as well. In this context, see Gupta et al. (1997).

[25] I have borrowed this term from an Egyptian study of women's reproductive lives. It is a useful analytical tool to understand how unmarried girls who work in companies comply with the discriminatory and sexually exploitative work culture against their own wishes for the sake of deriving some strategic benefits like income and some freedom and mobility. At the same time, they constantly complain and regret the situation they are in. Here, we can see 'accommodation' interacting with 'resistance'. For a detailed discussion on 'strategic accommodation' see El Dawala et al. 2001.

[26] We have no quantitative data on the increase of abortion among unmarried women and we have based our argument on the views expressed by medical personnel and the people in the study villages.

[27] In another context, critiquing the abortion laws in India, Malini Karkal comments that in India, liberal laws like MTP are closely linked to the national family planning programme which encourages good abortion facilities and abortion care. But this would only lead to an increase in the number of abortions with an adverse effect on women's reproductive rights and choices. See Karkal (1991).

Abortions in Rural Communities near Urban Areas

The Experience of Married Women

ANJALI RADKAR

INTRODUCTION

The International Conference of Population and Development (ICPD) iterated an important goal when it stated that 'every pregnancy should be intended' (Tsui et al. 1997). As it is a global problem, determining the extent of unwanted pregnancies that end up in induced abortions will be of great value from several vantage-points.

Unfortunately, abortion is still one of those issues in women's lives that are buried in silence. In a country like India, women's health is given very low priority and their lack of control over family resources denies them access to health care in general and abortion in particular. In addition to being considered dangerous, abortion is also socially unacceptable.

Studies in many developed or developing countries show that, even where abortion is legal, women are reluctant to talk about it (Bart and Hill 1996). In India, its incidence is always under-reported, either because of a feeling of guilt or because of the moral stigma associated with it. Some studies have estimated the extent of under-reporting to be about 50 per cent (Das 1989; Tiwari 1994). Many researchers have also shown that the ratio of illegal to legal abortions (at 8–11:8) is highly skewed (Chhabra and Nuna 1994; Jesani and Iyer 2000). Because of illegal abortions, there are between 15,000 and 20,000 abortion-related deaths in the country every year, mainly among married, multiparous women (Chhabra and Nuna 1994). But even generally, deaths due to induced abortion are quite high and comprise a large share—17.6 per cent (in 1995)—of maternal mortality (Bandewar 2002). It is therefore evident that legalisation of abortion is a necessary but not sufficient condition for reducing the number of unsafe abortions.

Abortion was liberalised in India after the 1971 Medical Termination of Pregnancy (MTP) Act came into effect on 1 April 1972, according to which a pregnancy may be terminated within 20 weeks of gestation. Before 1972, abortion was permitted only if it was necessary to save the life of the woman. Now, it is also allowed on grounds of preserving her mental or physical health. It is also considered legal in cases of pregnancy due to rape or incest, or in cases of contraceptive failure. However, it is illegal if performed just because a woman (or some other person) requests it, or if it is demanded only for social and economic reasons (United Nations 1993). The Indian government has also repeatedly emphasised that MTP should not be viewed as a method of family planning or for reducing national birth rate.

A large chunk of abortions is now cited as falling under a special class that was almost non-existent at the time of framing the Act. It constitutes sex determination followed by abortion of the female foetus. In this case, it is not the pregnancy but its outcome that is unwanted. The first sex-selective abortion was documented

in India in the 1970s, with the advent of amniocentesis. Chromosomal analysis of amniotic fluid was developed for the diagnosis of sex-linked genetic disorders. However, almost immediately it began to be used in genetic clinics for determining the sex of the foetus in order to avoid the birth of girls (Oomman and Ganatra 2002).

Legalising abortion also brought with it the need to create more MTP facilities. After the Act was passed, the number of abortions is reported to have increased 22 times, while the availability of approved centres has gone up just five times. Differentials by state in the number of MTP centres reveal that their number is higher in more developed states. Similarly, rural–urban distribution of the centres is skewed as most of the centres are in urban areas, particularly in bigger cities. Barely 10 per cent of the primary health centres (PHCs) provide abortion facilities to about 60 per cent beneficiaries. As this service is concentrated in urban centres, unsafe abortions continue to be performed in rural and remote areas.

Despite the fact that it is now thirty years since MTP was legalised in India, women still fight shy of speaking about it. This has proved to be one of the major stumbling blocks in gathering information about the extent of foetal wastage in general and induced abortions in particular. Large-sample fertility surveys have made efforts to collect this data, but without much success. There are some clinic-based studies that provide some information about abortions, but this is also incomplete since the sample used is very selective and it is difficult to extract information about the processes and patterns associated with abortion from this data. It is this lack of reliable data that necessitates a study devoted only to abortion. Such a broad-based, qualitative study on abortion can shed light on the processes and patterns of abortion, as well as the associated underlying factors. Using a purposive sample, information collected on decision-making, rationale, attitudes and perceptions, quality of care and cost, and post-abortion reactions would explain some of the hidden aspects of abortion. Our study is structured taking into consideration all these factors.

PROFILE OF STUDY AREA

In our study, we chose to focus on two purposively selected villages—X and Y—on the fringe of Pune city. The nature of villages on the urban fringe is somewhat peculiar: though the living conditions of people there can be described as rural, they are employed in both agriculture-related and urban occupations. Because of the increase in transportation facilities, commuting to nearby urban centres is easier, as is access to urban infrastructure. Unlike their rural counterparts in remote, interior parts of the region, the women in these villages can access abortion services provided by various public and private health centres in the city.

Village X is located 15 km and Village Y about 20 km away from Pune city. Both villages come under Mulshi tehsil of Pune district, which is a hilly region, characterised by heavy rainfall. The 1991 Census of India reported the population of these two villages to be 2,471 and 1,847 respectively.

Of the two, Village X is the bigger village. It is planned that the new state highway will cut right across it. Most of the people here belong to the Maratha community of upper-caste Hindus. The land in this area is irrigated and fertile, with the major crops cultivated being rice and groundnut. People also grow vegetables and various seasonal fruits. Though Village X has only one *wadi* (hamlet), namely Matalwadi, it is a large one with about 130 households, of whom almost all are engaged in agriculture. Occupying an area of about 2.5 km, the hamlet is situated on a small hill to the west of the main village. No public transport is available in the *wadi*, and people have to walk down to the village for everything. Perhaps because of this, it is less modern than the main village.

Owning a farmhouse near the city has become a very popular trend in Pune, with an increasing number of people buying a small piece of land outside the main city to build a small house. Village X has not escaped this trend. Also, given its proximity to the city and the penchant of urbanites to eat in restaurants outside the town area, several *dhabas* (small eating houses) have come up in and around Village X. This has meant that the people here have a lot of ready cash, which they can easily use in case of emergencies like abortion.

Village Y is a comparatively smaller village. It is about 2 km away from the main highway. The road leading to it is still *kachcha*, but is well maintained. Public transport is not available inside the village, where only private vehicles are in use. However, access to all sorts of transport facilities is just a 10 to 15 minutes walk away. Unlike Village X, not many people in Village Y have sold their lands to city-dwellers and most still depend on agriculture. The major crops here are rice, ground-

nut, beans and seasonal vegetables. Situated in the hills, Village Y has six small *wadis* around the main village: Angrewadi, Khatpewadi, Varpewadi, Waghwadi, Wahalewadi and Pansare Wasti. Of these, Angrewadi and Khatpewadi are bigger with about 75 to 80 households each, while Wahalewadi is the smallest and has only four households. The remaining three have about 15 households each. All the hamlets are picturesque and surrounded by small hills and greenery.

THE STUDY

The main objective of our study was to understand the entire process of abortion, from thought to action and thereafter. However, our specific goals were:

- To know about the role of women in decision-making about abortion.
- To understand more about the role played and support offered by the family.
- To get detailed information about the reasons for abortion.
- To understand the extent of sex determination tests and female foeticide.
- To know about women's choice of provider, quality of care and cost of abortion.
- To get information on contraceptive use after abortion.
- To know about abortion-related trauma.
- To understand the perceptions of men and village functionaries relating to abortion.

METHODOLOGY

An initial household survey was conducted in both villages to locate currently married women of reproductive age (15–49 years). All these women were then interviewed in depth to identify those who have sought induced abortion at some time in their life. Apart from collecting background information, we also collected detailed histories of all their pregnancies so as not to miss any instance of foetal wastage. Additionally, information on their attitude towards and awareness about the legal aspects of abortion and prenatal sex determination was gathered.

The two main methods used to gather data were:

- In-depth interviews
- Focus group discussions (FGDs).

In-depth Interviews

We conducted detailed interviews of women who have sought abortion in order to get a holistic picture of all the factors involved—why, where and how. However, we felt that collecting information from women alone would not be sufficient. Village functionaries, opinion leaders and health personnel could also help us to understand the issue from other angles. We therefore included the *sarpanch* (headman) in both villages, doctors from both public and private health services, as well as the chemist in Village X in our list of interviewees. Since the selected villages come under sub-centre (SC) Pirangut and PHC Paud, the medical officers and auxiliary nurse midwife (ANM) working there were also interviewed.

Focus Group Discussions

FGD is an excellent method for eliciting information related to attitudes, beliefs and reported behaviour. Therefore, apart from in-depth interviews with women seeking abortion, five FGDs were conducted with women who have not sought abortion in order to gauge their attitude to and knowledge about issues surrounding abortion.

Women generally do not make decisions about abortion by themselves. Their husbands have a major say in the matter. We therefore felt it was necessary to learn something about men's perceptions of and attitudes to abortion. Accordingly, we conducted three FGDs with the men in the study area.

Since unmarried adolescent girls would also enter into reproductive life at some time we conducted FGDs with them as well. After talking to the men and adolescent girls, we thought that discussions with adolescent boys would further add to our knowledge of abortion in the selected villages. Boys are a curious lot and keep a tab on all village happenings. In each village, therefore, we held an FGD with adolescent boys.

In the end, a total of twelve FGDs were conducted to study the phenomenon of abortion in the two villages.

Ethical Concerns

- The informed consent of respondents was sought before starting the interviews.
- Since we were collecting information on a sensitive issue, care was taken to maintain privacy during the interviews.

- The names of the women and content of the interviews were kept confidential.
- Provision was made to disseminate the findings of the study through meetings in both villages.

FINDINGS

Survey Findings

As mentioned earlier, information was collected both from households and all currently married women in the reproductive age group.

We visited all 940 households during the course of our research—556 (59 per cent) in Village X and 384 (41 per cent) in Village Y. The total population covered was 4,755, of which 2,520 were males and 2,235 females, with the sex ratio (females per 1,000 males) standing at 887. The 1991 Census reported the combined sex ratio for these two villages as 906, a figure that is sharply skewed against women. However, our survey has carefully listed all household members, so under-reporting of females seems to be unlikely. Like the Census, we too computed the sex ratio of children below 6 years of age, which we determined as being 927. Ideally, in a situation of no missing females, it would have been 952.

Eight female foeticides were reported in the study area, of which six took place in the last six years. Even if we take only these six foeticides into account, the child sex ratio would have been 945. It is clear from this that female foeticide directly affects the child sex ratio.

Forty per cent of the population in the study villages is less than 20 years old, while about 9 per cent is of 60 years and above. The percentage of illiterate females (31 per cent) is considerably more than that of males (13 per cent), though it is almost at par for various other categories of educational level up to SSC. Again, females lag behind males where higher education is concerned. Among those who have completed degree courses, 22 males and 8 females are highly educated in that they are either postgraduates or professionals like lawyers, engineers or doctors.

Fifty-three per cent of the females in the study population are currently married. Since the villages are situated on the urban fringe, their family pattern is similar to that of urban areas, i.e. there are more nuclear than joint families, with the latter accounting for only 40 per cent of all families.

Classification of households by religion shows that respondents from 95 per cent of households are Hindus and a little more than 4 per cent are Buddhist. Other religions comprise just 1 per cent of the households. Among the Hindus, the dominant caste comprises the Marathas, who are the major landholders of the region.

The occupations in which the villagers are engaged give us a basic idea about the social and economic status of the households. As expected, agriculture is the main occupation reported by 44 per cent households. Then there are jobs, particularly clerical jobs, in various government and private offices and banks, which are reported by 18 per cent of households. About 17 per cent households are employed in sales-related jobs, while 80 households, i.e. 9 per cent, work in the construction business as masons, plumbers, etc. Seven per cent of the households are engaged in agricultural labour, while 6 per cent hold jobs related to transport. Thirteen households reported being employed either as officers in government service or as lawyers. The remaining are gardeners, *veet bhatti* (brick kiln) workers or boatmen.

Based on the type of house, its ownership and the presence of various household amenities, we have classified households as having a low, medium or high standard of living. This is a proxy indicator of their economic condition. Their distribution by standard of living shows that 70 per cent fall in the 'medium' category. Of the remaining, 20 per cent emerge as having a 'low' standard of living, with only 10 per cent laying claim to the higher category.

We interviewed 933 currently married women in the reproductive age group—562 (60 per cent) in Village X and 371 (40 per cent) in Village Y. Since about two-thirds of the women belong to the younger age group, i.e. are below 35 years, the views represented in this study can be said to have been influenced by the younger lot.

Age at marriage for females is an important indicator of social development. The mean age at marriage of females in the study area was determined to be 16.3 years, while the median age was calculated as 16 years. According to NFHS–2 Maharashtra (1998–99), the median age is 16.4 years. About 69 per cent, i.e. 648 women, were married before they had completed 18 years. This is disturbing, considering the proximity of the study villages to a large urban centre.

Our data show that in the two villages, the average number of children born and surviving per woman are 2.52 and 2.35 respectively. Table 1, which shows the average number of total pregnancies and abortions, gives us a rough idea about the reproductive health of women.

Table 1: Averages of Pregnancy Outcomes

Pregnancy Outcomes	*Averages*
Live births	2.52
Spontaneous abortions	0.14
Induced abortions	0.08
Still births	0.05
Total pregnancies	2.79

The average wastage per woman is thus 0.27. Based on the experiences of all women in the two villages, we can conclude that pregnancy wastage is not very high in the study area.

Table 2: Percentage Distribution of Pregnancy Outcomes Estimated by Current Study, NFHS–2 Maharashtra, and Shah Committee

Pregnancy Outcomes	*Current Study*	*NFHS–2 Maharashtra*	*Shah Committee*
Live births	90.3	92.8	73.0
Spontaneous abortions	5.0	3.8	10.0
Induced abortions	2.9	1.9	15.0
Still births	1.8	1.5	2.0
Total pregnancies	100.0	100.0	100.0

The reported foetal wastage in the current study is about 10 per cent compared to 7 per cent reported by NFHS–2. But both these are far lower than the estimate provided by the Shah Committee.

With regard to the use of contraception, our research shows that sterilisation is the most widely accepted method of family planning. Ninety per cent of the current users of contraception have opted for sterilisation. (While the contraceptive prevalence rate for all methods is 75 per cent, sterilisation accounts for 67 per cent of it.) Spacing does not seem to enjoy much popularity as a family planning method, and this is reflected in the fact that only 10 per cent of the couples reported its use, with 14 couples using traditional methods like safe periods and coitus interruptus.

In the following paragraphs we discuss women's general views on abortion: whether or not they approve of it, whether they are aware of the MTP Act, and what, according to them, are the most likely reasons for abortion.

Most women (90 per cent) in the study villages do not approve of abortion. Only 4 per cent seem to view it in a positive light. Forty-nine women said that while in some cases abortion may be justifiable, this is not always the case. Not surprisingly, 62 per cent said that it 'is killing', while 36 per cent condemned it as 'a sin'. Some of them (36 per cent) also said if couples do not want a child, they should take precautions to prevent the women from getting pregnant.

According to 84 per cent of the women, the most probable cause for abortion is reluctance to have 'a female child'. About 20 per cent of them stated that women go in for abortion because they want to limit the family size and then get sterilised, while 10 per cent felt that abortion is used for spacing between children. Surprisingly, very few respondents (23 and 13 in the two villages respectively) mentioned 'improper growth of the child' or 'trouble to mother' as a reason, though these two are perhaps the most 'valid' among all the reasons postulated. The women's responses quite clearly indicate that whenever women think of abortion, the first thing that comes to their mind is abortion of the female foetus. There is thus a very strong association between abortion and female foeticide.

When we asked the women if they knew that abortion is legal in the country, only 47 per cent responded positively. When we further questioned them about the reasons for which abortion is permitted and the period of gestation within which it is considered legal, only 37 women showed awareness of the Act's provisions. Almost all of them said that the duration of pregnancy within which abortion is permissible is below five months.

Qualitative Findings

In order to better understand the process of abortion, we decided to carry out detailed interviews with women who had undergone abortion. In cases of repeat abortions, we conducted a separate interview for each abortion because we felt the reason, gestation period and conditions in the household would be different for every incident. In the event, we collected and analysed data for 70 abortion episodes.

Between them, 65 women experienced 70 abortions. While most had undergone only one abortion each, four had gone through repeated abortions. Among them, three had sought it twice, while one had undergone it thrice. Two women had repeat abortions for medical reasons, while two others used it as a method of spacing. Fifty of the 70 abortions took place in Village X and 20 in Village Y. As stated earlier, considering its large size

and proximity to the city, as well as the better connectivity it enjoys, it is not surprising Village X reported a higher number of abortions. All the abortions included in this study took place between 1985 and 2002, over a period of seventeen years.

Understanding the differentials in the proportion of women seeking abortion by their characteristics can shed light on the circumstances surrounding the reasons that lead to abortion (Bankole et al. 1999). We therefore made an effort to study the background and demographic characteristics of abortion seekers in terms of educational level, occupation and standard of living. These are presented in Table 3. In 65 of the 70 episodes of abortion, the women were below 30 years of age; only in five cases were they 30 years or above. The median age at abortion is thus 23 years. In 12 or 29 per cent of the cases, the age at abortion was 20 years or less. This is in line with the findings of hospital-based studies on abortion conducted by Chhabra et al. (1988) and Solapurkar and Sangam (1985), which quoted a percentage of 27 and 30 respectively. The age of women seeking abortion shows an inverted U pattern in the study area, similar to that described by Bankole et al. (1999). The reason for this is that as they grow older, fewer women seek abortions as most of them are sterilised by then.

The proportion of educated women among abortion seekers is higher than among the entire population. Khan et al. (1990) and Chhabra et al. (1988) also found the proportion of illiterate women among abortion seekers to be low. Confirming the findings of the ICMR (1989) study, our research revealed that the educational level of 12 per cent of the abortion seekers is above SSC level, while the percentage of such women in the general population is just 6. Twenty-eight of the abortion seekers are housewives, indicating they do not need to work for money. As regards the occupation of others, most are in agriculture and allied activities. Four of them run a shop, three run tailoring businesses, one is in gardening and two are self-employed, indicating that they probably have some money of their own. Further, 15 per cent of the abortion seekers enjoy a 'high' standard of living as compared to 10 per cent in the population. In combination, all these factors enhance women's ability to take—and act upon—a decision on abortion when faced by the occurrence of unwanted pregnancy. In the study area, therefore, abortion seems to be a phenomenon related to younger and more educated women with a better standard of living.

Table 3: Background Characteristics of Abortion Seekers

	Number
Educational Level	
Illiterate	13
Class I– IV	13
Class V–IX	20
SSC	11
Above SSC	8
Occupation	
Agriculture	25
Agricultural labour	2
Shop	4
Gardening	1
Self-employed	2
Tailoring	3
Housewife	28
Standard of Living	
Low	5
Medium	49
High	11
Total	65

In addition to information on their current status, we felt that it would be useful to note the women's reproductive histories at the time of abortion. We discovered that 49 of the 70 abortions were of third or fourth order of pregnancies, while only two were of first order. Since abortion is more prevalent among women in the younger age groups, the number of children that these women have is also low. In the case of 54 abortions, women had two or less number of surviving children. Among them, the average number of surviving sons was less than one (0.8) and surviving daughters a little more than one (1.1).

Attitude towards Abortion

Women's attitude towards abortion presents a mixed picture. Forty-nine of the 65 women who sought abortion said that abortion is wrong; only according to five was it justified. Ten women could not decide whether it was right or wrong. One woman said that abortion in the case of a deformed foetus is justifiable. The women also appear to have a strong gender preference. Four wanted at least one son, and so viewed abortion (in the hope that the next time they will bear a son) in a favourable light. However, three women condemned the idea of aborting a female foetus. In general, they perceived abortion as '*hatya*' (killing) (29) or as a 'sin'. Among other opinions, physical 'trouble' to women was

cited as another reason for eschewing abortion. However, three women justified abortion as a spacing method. One of them said: '... *aadhichya mulache hal nako*' (earlier child should not suffer). Economic considerations (4) and too many children (3) were two other reasons for justifying abortion.

We had expected that since 65 women had undergone abortion, they would have a favourable attitude towards it. Our study does not show this unequivocally. We found that, as a rule, the women in the study area do not approve of abortion. Women who have undergone it have done so for lack of other alternatives.

Table 4: Reasons Underlying Motivation for Abortion

Reason for Abortion	*Number*
Spacing between children	17
Limiting the family	33
Female foeticide	8
Contraceptive failure	4
Problem to mother	15
Problem to child	1
Weakness	5
Economic reasons	3
Medical advice	11
Retarded/handicapped child	3
Already had a son	1
Pregnancy immediately after marriage	1
Twins	1

PRE-ABORTION

Why Pregnancy Was Considered Unintended

Research revealed that not all pregnancies started out as being unwanted. Rather, certain circumstances during the course of pregnancy made them unwanted, such as the discovery that the foetus was female. Similarly, in lower order pregnancies, the child was wanted but the timing was wrong. Sometimes, the question of being wanted or unwanted did not apply: pregnancy was discontinued for medical reasons.

Reasons Underlying Motivation for Abortion

The reason why a woman seeks abortion may differ from one abortion to another, depending on her socio economic situation and the stage of life she is in at the time of seeking abortion. However, for most women, abortion means loss—loss of money and some loss of health. Our study reveals very clearly that the decision to abort is taken not just individually by the woman, but thoughtfully, by the family as a whole.

Women's responses when questioned about the reason why they had sought abortion were varied. In several cases, the responses implied multiple reasons, suggesting that the decision to abort is a complex phenomenon. However, when we isolated the responses, we found that in 33 cases the reason was to limit the family size, and in 17 cases abortion was used for spacing purposes. Similar percentages for limiting family size and spacing are found in Ganatra et al. (1999), ICMR (1989) and Khan et al. (1990). According to Bankole et al. (1998), the most commonly reported primary reasons for abortion in Asia are the desire to postpone and/or stop childbearing. Of the two, the latter appears to be more prevalent. This finding is consistent with the widespread preference for smaller families in most Asian countries and with the fact that more married than unmarried women undergo abortions.

With regard to spacing between children, we analysed our data to determine how many women knew the sex of the child before abortion. Our analysis leads us to conclude that though women do want sons, they are not in a hurry to have one. In 11 out of 17 cases, the sex of the child prior to abortion had been male. However, eight, i.e. 11.4 per cent women reported seeking abortion because the foetus was female. Studies by Ganatra et al. (1999) and the Voluntary Health Association of India (1999) show similar percentages: 16.8 and 10 per cent respectively. Seven of the eight women in our study had undergone ultrasound imaging, while one had had amniocentesis done.

In the study area there is a woman who is 30 years old, is educated up to Class IV and has four daughters. Her mother-in-law constantly threatens her that if she doesn't produce a male child she will get another wife for her son, and throw her and her daughters out. If this really happens, where will the woman and her four daughters go? So when she got pregnant for the fifth time, she went in for a sex determination test and, since the foetus was found to be female, decided to have it aborted. We got this information during the informal discussion that took place after the formal interview was over. In the interview itself, she had explained away the abortion by saying that the foetus had not been growing properly. However, she made it clear that, in principle, she does not approve of abortion, particularly female foeticide.

The health of the mother is cited as another reason

for abortion. This includes problems during pregnancy, particularly in the early stages. Two women reported heart trouble and one a prolapsed uterus as the reason for abortion. Another five reported physical weakness. In three cases, women had undergone abortion for economic reasons. In one case, the woman said that *'son was born already'*, while in another case the woman concerned did not want to have a baby immediately after marriage.

In addition to these reasons, women also resort to abortion because of some unforeseen circumstances. There was one peculiar case where the reason given was that the *'husband wanted to get married again'*! In her own words:

> My husband had relations with some woman and he wanted to get married to her. He always used to tell me: 'You are dark. I don't like you'. When he knew that I was pregnant for the second time, he ordered me to have an abortion. When I refused, he said, 'I won't be responsible for whatever happens to you later', and walked off. So I got it done.

In another case of pregnancy eight years after sterilisation, the woman's husband and sister-in-law forcibly took her to the hospital for an abortion. When she discovered she was pregnant, the woman's natural instinct was to continue the pregnancy, particularly because she had only two children. At the same time, she also felt embarrassed. However, nobody heeded her and she had to undergo abortion followed by re-sterilisation. During an FGD, a young man in Village Y described pregnancy after sterilisation failure as a calamity. *'What can we do if it rains heavily after the rice is cut and kept out?'* he said.

According to government statistics, about 40 per cent of abortions take place due to contraceptive failure, and it is valid for the MTP Act to include this as a reason for permitting abortion. However, as mentioned earlier, only four women in our study sample cited this as a reason. In three cases, pregnancy was due to the failure of Cu-T (Copper-T), while in one it was due to sterilisation failure. The use of spacing methods in the study area is in any case low, and those who do use them, do not do so effectively. Since the study population is well aware of this fact, except in the four cases we have described, no one gave contraceptive failure as a reason for abortion. Ganatra et al. (1999) and Srinivasa et al. (1997) also found that contraceptive failure as a reason for abortion was only true in 5 per cent of the cases.

Sex Selection

We also attempted to gauge how many of the women who have sought abortion find sex selection justifiable. While 16 of them were 'for' prenatal sex selection, 38 were against it. Ten said that sex selection is justifiable only if the woman already has a large number of daughters. Strikingly similar views were expressed during all FGDs with women in both villages, reflecting perhaps the existence of son preference and facilities for conducting the test nearby. Shah and Taneja (1991) have also pointed out that there is widespread acceptance of sex detection followed by abortion.

Sex detection with amniocentesis is usually done at around 16 to 20 weeks of pregnancy, whereas it is done at 13–14 weeks using ultrasound imaging. In this context, it is important to note that the accuracy of detection enhances with increased duration of pregnancy. *Chorionic villus* sampling is a more advanced test that can detect sex at as early as 6–7 weeks of pregnancy, but it is generally used to detect genetic disorders, if any, in the foetus. When the embryo enters the uterus it is surrounded by *chorionic villi* which fit into the lining of the uterus. Scraping these *villi*- for sex detection needs expertise, because if something goes wrong the risk of damaging the embryo is quite high. A private doctor, according to whom sex determination is rampant in urban areas, told us:

> It is good that not all know about *chorionic villus* sampling and not many doctors can conduct the test, otherwise the rate of abortion would increase very much. At least some women are scared to go for second trimester abortion after sex determination by ultrasound.

In urban areas, ultrasound imaging is fast becoming an integral part of antenatal check-ups to determine whether the baby is normal. Since the women in the study area also prefer to go to the city for delivery, there is a distinct possibility that apart from routine check-ups, they use ultrasound imaging to detect the sex of the foetus. Nineteen women in the study area reported that they did take this test. Eight of them admitted that they used it for sex detection, whereas in eight other cases, the doctor had suggested the test to determine the health of the child/mother. In two cases it was done either to confirm the pregnancy or to estimate the duration of

gestation. After the test, nine mothers knew the sex of their foetus, which in eight cases was female.

However, one woman from Village X reported that she underwent amniocentesis solely for sex determination. She is 30 years old and already has two daughters. The family is educated and economically well off. The husband appeared to be supportive. The couple went to Mumbai for the test in 1992. When they discovered that she was carrying a female foetus, they decided on an abortion. Without informing her in-laws, she had the abortion in the fifth month of pregnancy and consequently suffered from post-abortion trauma. The in-laws were not very happy that she had aborted but they supported her. The woman herself has a very strong son preference, but she asks: '*How many girls should one have?*'

We also discovered that two of the 65 women had undergone an ultrasound test during a previous pregnancy. They continued the pregnancy because the foetus was determined as male. But the fact that 23 of the 65 women did not have any surviving son at the time of abortion calls for further investigation. Among the 23, only eight were first trimester abortions, with the remaining 15 having taken place during the second trimester. The reasons for abortion, as given by these 23 women, are tabulated in Table 5.

Family size has been coming down steadily in the area, and in villages on the urban fringe it is already limited to two children. Considering the preference for sons, there is always the possibility that those who have two or more surviving children and no son may resort to sex determination followed by abortion. Even where women report undergoing abortion for reasons of spacing or limiting the family, contraceptive failure or 'problem to mother', at least in some of the cases it is possible that desire for a son, though not explicitly stated, was the main reason for abortion.

Table 5: Number of Surviving Children and Reasons for Abortion Given by Women with No Surviving Son at the Time of Abortion

	Number
Number of Surviving Children	
0	6
1	6
2	6
3	4
4	1
Reason	
Female foeticide	8
Pregnancy immediately after marriage	1
Spacing between children	2
Limiting the family	1
Contraceptive failure	1
Problem to mother	9
Problem to child	1

A woman of 35 had three daughters in a row. The fourth time she conceived, she took a sex detection test and aborted the female foetus in the fifth month. As this abortion had caused her health problems, she did not take the test when she conceived again and delivered yet another daughter. Now she has four daughters. She said that the next time she conceives, she will take the test and if the foetus is female, get an abortion and sterilisation done at the same time.

In all the FGDs—with men, women, and adolescent boys and girls—it very clearly surfaced that women who go for sex determination follow it up with abortion of the female foetus. Everyone seemed to know at least some women who had done this. The adjectives they used were '*raggad*' and '*chikar*', both indicating 'so many'. For them, sonography is to sex detection what family planning is to sterilisation. One woman, who lives in Village Y, said: '*These days, getting sonography done is a fashion.*' Another (in Village X) said: '*Sonography has become a fad now.*'

But we also came across cases where sex detection had failed. For example, a woman in Village Y took the test because she already had three daughters. The results showed a male foetus, so she continued the pregnancy but ended up delivering a daughter again. All the women in the village knew about this, and she was extremely embarrassed when they brought it up during the FGD. In a second case, a woman from Village X accompanied her pregnant sister, who already had one daughter, to the city for sex detection. At first the doctor, who was known to the woman, declined to do the test, but later performed it at the request of the woman. The results indicated a female foetus, so the woman insisted that her sister abort the pregnancy. Again, the doctor was reluctant to perform the procedure as the pregnancy was already in an advanced stage, but in the end was persuaded by the woman to go ahead. When they learned that the baby had been a male, they regretted their decision. After this episode the sister got pregnant again and delivered a daughter. She told the woman: '*Now I will*

never listen to you. If the time comes, I will get sterilised with only daughters.'

Sex selection was a topic on which everybody seemed to have fairly accurate information; it was also a topic on which everyone had an opinion. Universally, all women were in favour of sex detection in cases where the couple has daughters but no son. All of them felt that a son is a must. When the discussion veered towards whether sex detection is right or wrong, one 40-year-old woman from Village Y exclaimed: '*Why do you blame our women? Did they know earlier that sex of the child could be detected before birth? It is the doctors who told us about it.*' But when we pointed out that there are many things that doctors advise, particularly in terms of antenatal care or the health of the mother and children, which the women do not heed, the reply was: '*A person takes whatever she likes in the advice.*'

However, an elected member of the tehsil's Panchayat Samiti, who participated in our FGD with the men in Village Y, said that: '*Sex detection may be a common practice in the (your) city. In the villages women don't even go for antenatal check-up, so forget about the test and abortion.*' Similarly, it was evident from our interviews with the *sarpanch* in the two villages that they speak the politically correct language. Both of them blatantly denied the occurrence of sex detection and abortion of the female foetus in their respective villages. Further, they said that abortion itself is very rare and if it happens at all, it is only for 'valid' reasons.

Many women in the study area were aware of the fact that abortion of the female foetus is a punishable offence. At least one or two women in each group were aware of the declining sex ratio and were also worried about its consequences in the long run, particularly that '*our sons will not get wives.*'

In all the interviews we conducted, there was an underlying feeling that for most rural women, *sansar* (married life) is like a career, and having son is an indication of success. It is an important milestone, which they must all reach as fast as they can.

Secrecy about Pregnancy

Information on the secrecy surrounding pregnancy is usually collected to get an idea of whether women feel guilty about their pregnancy or are embarrassed about letting others know about it. In our study, there was no report of any secrecy relating to pregnancy, perhaps because all our respondents are currently married women. There was only one case where the husband was not aware of the pregnancy because earlier the woman had borne two mentally handicapped children and her husband wanted one more child—a son. He felt that this was possible because the woman had also borne one daughter who was absolutely normal. In all other 69 cases, the husband was aware of the pregnancy. In 50 cases, the mother-in-law also knew about the pregnancy. It can therefore be assumed that the husband and his family usually know if the wife is pregnant. In fact, the first person to be consulted when there is an unwanted pregnancy is often the husband (Sinha et al. 1998).

Decision-making and Role of the Family

Making decisions about abortion is a dynamic process. We therefore felt that it would be useful to understand with whom women discuss their pregnancies and who advises them to have an abortion. The role that women play in the decision-making process is also of interest whenever abortion is discussed. We found that the woman herself was involved in decision-making in 51 cases, and the husband in 57 cases. In 49 out of 70 abortions, it was a joint decision by husband and wife. In four cases the mother-in-law was involved. The role of the husband in decision-making is thus much more important than the woman's.

When asked whether they themselves had wanted the abortion, the answer was 'yes' for 54 episodes of abortion. In one case, since the abortion had been sought for economic reasons, the woman was confused about whether she had wanted it or not; in 15 cases, however, the women had not wanted the abortion. Our attempts to discover why, despite not wanting it, the women had gone ahead with the abortion revealed that in 11 cases the abortion had been for medical reasons. In one case the husband had forced the woman to abort, and in another the in-laws had wanted a son. One woman gave sterilisation failure as the reason: '*I felt ashamed when I got pregnant after the sterilisation. So I had no other alternative but to terminate.*' Another woman did not want abortion but was compelled to seek it for economic reasons.

When, during our FGDs with men in both Village X and Village Y, we asked them about the role that the woman's parents play in the issue, their unanimous response was 'no role'. As a rule, they are not even informed about it, though sometimes after abortion women do go to their parents' home for a rest. The men

also emphasised that it is the usually the husband who takes the decision on abortion; more often than not, the women are just pressured into saying 'yes'. However, in case the couple has a large number of children, the woman *may* take the decision herself. As one man mentioned: '*Women here have not progressed so much that they will take the decision themselves.*'

Generally speaking, we found that abortion is very much a personal decision of the couple, though the family and people around do have a role to play. Family support and someone from the family to accompany the woman to the clinic at the time of abortion are considered necessary. To explore this issue further, we asked the women whether, in order to avoid others knowing about the abortion, they had kept their pregnancy a secret. Only 13 replied in the affirmative; the remaining 57 women said that there had been no secrecy. Even among the 13 women who had kept their pregnancy hidden, the husband, and in some cases, the mother- and father-in-law, knew about it. But we could discern no specific reason for abortion in the instances where secrecy had been maintained. The usual reasons seemed to apply: abortion was either for spacing between children, or to get sterilised, or because of medical advice. Where abortion of the female foetus after sex detection is concerned, it is not possible to hide this from the other villagers. By the time the test is conducted, the pregnancy is already in an advanced stage (four to five months). In addition, it is usually women with daughters but no son who undergo such abortions, so everyone in the village knows about it.

In terms of family support, 50 women said that the husband was supportive. In 18 cases all the family members were supportive, and in 12 cases the support of parents-in-law was mentioned. However, from the women's responses we gathered that by 'support' they generally mean permission and approval. Most of them said: '*If they (family members, especially mother-in-law and sister-in-law) don't approve of abortion, how can I get the required rest? Who will look after my children when I am away in the hospital?*'

Similarly, without family support or approval, there would be no one to accompany them to the hospital at the time of abortion. In 52 cases, women reported that their husbands had accompanied them. Among these, in 24 instances, it was *only* the husband who accompanied them, but in the remaining 28 another family member was also present. In terms of other family members, we found that the mother of the woman (16) generally accompanies her more often than the mother-in-law (8) or any other relative.

Choice of Provider

It is common for women who find themselves saddled with an unwanted pregnancy to first try and do something about it themselves. They usually try out some home-grown method to harm the foetus so that it drops on its own and no one else gets to know about the pregnancy. These are actually induced abortions, though they are seldom reported as such. Thus, when we talk about abortion service providers, we need to put women themselves at the top of the list. If they do not succeed in their first attempt, they consult a family member or friend and try again. Only if they fail again do they approach the real service providers. Of the 70 women in the study area who had undergone abortion, four reported having tried something on their own. During our FGDs, women from both villages claimed to have tried methods like eating a whole papaya, jackfruit, or several bananas (Shrotri et al. [1980] reported a similar finding). A woman who is 50 years old and is the mother-in-law of two respondents who have undergone abortion said:

> I had three sons and wanted no more. So the fourth time I ate a whole papaya twice, but nothing happened. Then I got the tablets for headache and had four at one time, still nothing happened. I think it is because our generation is much stronger constitutionally than today's women.

Another 33-year-old woman reported a self-induced abortion that took place fourteen years ago:

> I was having menses at the time of marriage. After marriage I did not get my periods. My husband did not like the idea of my getting pregnant immediately after marriage, so he was after me saying that I should do something and abort the pregnancy. I did not want to do that because does any mother feel that she should not have a baby? I knew that if a woman takes Anacin tablets, she gets her menses. So in the third month I got five Anacin tablets from the chemist and consumed all of them together. I aborted and got my periods. I did not tell anyone about this, not even the doctor.

After that she did not conceive again. She even went to Gujarat for treatment, but nothing happened. Her

mother- and sister-in-law keep threatening to get a second wife for her husband. Her usual answer is: '*Why one, bring five.*' But her husband supports her because he knows that it was on his insistence that she had the abortion. She sadly related what happened when she returned from Gujarat:

> After the treatment in Gujarat I did not get my periods for six months. I did not go to any doctor for a check-up. But I put on weight so everybody thought that I was pregnant. My mother- and sister-in-law got me a green saree and arranged a function. After the function I got my periods.

All the doctors reported that women try home remedies for abortion and only approach the doctor if they fail or suffer some serious consequence. One private doctor shared with us her knowledge of the methods women use to induce abortion, such as eating something they consider would be dangerous for the foetus, hitting themselves on the stomach, jumping up and down, or making their children stand on their stomach. While these are all dangerous, even more dangerous is the insertion into the uterus of objects like sticks of *Neem* and *Babhali*, matchsticks, needles, safety pins or hairpins. When they finally come to the doctor, many of them say nothing about their attempts. These are noticed when metal pieces come out with the aborted material, though things like sticks might disintegrate and sometimes go unnoticed. In the process of evacuating and scraping, metal pieces can injure the uterus, as abortion is often a blind procedure. Women do not understand the extent of risk they take by inserting objects into the uterus.

It is only when all home and traditional remedies fail that the decision to seek abortion from somebody else is finalised. In this regard, women have their own notions about where to go, depending on whether the conception is within marriage or outside. There is a strong belief that women who get pregnant as a consequence of *bhangad* (extramarital affair) generally go in for unsafe abortions.

This belief also came through in our FGDs with both women and men in Village Y. A 46-year-old man said: *'There are cases we know. They cannot go to the doctor openly so they have to go to quacks.'* When we asked him about post-abortion trauma in such cases, he replied: *'They do all this secretly. Whatever information we have is hearsay, so how can we investigate whether there was any trouble or not?'* We got a similar reaction from one of the women, who said: '*Why should women feel ashamed to go to a doctor if the pregnancy is within marriage?*'

When we spoke about using traditional healers, a woman from Village X very proudly reported: '*Now everybody goes to the doctor. Our village is not backward. People here are educated and can afford to go to the doctor.*' Not a single woman admitted having visited a traditional healer or quack for abortion. But since people also visit traditional healers for other health problems, even if they do go to such a healer for abortion it is easy to keep the purpose of their visit hidden. However, all of them mentioned that there is no healer around who practises abortion. This may well be true, as the women in the two study villages do have access to safe abortion services because of their proximity to an urban centre. In a city, anonymity—which is what most women, especially those in extramarital relationships, want—is also not a problem.

The study population has easy access to all Pune hospitals. They also have access to the health facilities provided by the government for rural areas, such as the SC at Pirangut and the primary health centre (PHC) and rural hospital (RH) at Paud. From Village X, however, Paud is farther away than some of the private hospitals in the city. While government centres charge a nominal fee for the abortion procedure, women (and those accompanying them) do have to spend an appreciable amount of time waiting for their turn. In the process they sometimes end up losing an entire day's work. They also have to pay for the medicines prescribed. Economically, therefore, they do not find much difference in costs between urban private health centres and government centres. They also feel that doctors in the private centres are more careful and, unlike government hospitals, have better equipment and facilities. In addition, their time is not wasted because private doctors are usually in a hurry to finish their work. On the whole, therefore, women prefer to use private abortion facilities.

In order to get more information on the providers, we asked the women to list the abortion facilities they had used. They reported a total of 45 providers. Of these, 32 are private clinics, 12 are public facilities (seven government or municipal hospitals and five trust hospitals) and one a clinic that is exclusively meant for abortion. Of the 70 abortions, 41 were conducted in private clinics, 15 in government or municipal clinics, eight in trust hospitals and six at the abortion clinic.

Women thus have a wide range from which to choose a facility that would suit their needs. When we asked them about why they had chosen a particular provider over another, 31 women reported that they chose a particular doctor or hospital because he/she or it enjoyed a good reputation. Thirteen said that they had known the doctor for a long time. The reputation of the facility thus carries a lot of weight while selecting a provider. In 14 cases, women chose providers because they levied lower charges and this would help women to save on expenses, and in 13 cases women chose hospitals or clinics that were closest to their homes. In some cases, where the company in which the husband works reimburses medical expenses, the choice depended on the facility with which the company had an arrangement.

In our attempt to search for a link between the provider and period of gestation, we discovered that half of the first trimester and three-fourths of the second trimester abortions were conducted in private clinics. A visit to the PHC or RH is strongly associated with sterilisation. Usually, government servants working in the villages take 'cases' to these hospitals. In our study, 14 of the 33 who sought abortion and sterilisation together visited either the government health facility or some trust hospital, which functions more or less like a government hospital and charges a comparatively lower fee than private clinics.

From our discussions with the women in the study area it was clear that they do not go to traditional healers for abortion. All those interviewed seemed convinced that when abortion is performed in safe conditions, it poses little risk to women's health.

THE ABORTION EXPERIENCE

Duration of Gestation

First trimester abortions are quite safe if conducted by qualified medical personnel, but second trimester ones carry a definite risk and are comparatively more dangerous and hazardous for the health of the mother. All women respondents knew this because in 65 cases, the women had already borne and delivered one child at the time of seeking abortion. Classification of women by the duration of gestation shows that 46 abortions took place in the first trimester (66 per cent) and 24 during the second trimester (34 per cent). According to Solapurkar and Sangam (1985), who report a similar finding, 71 per cent of abortions among married women were in the first trimester and 29 in the second trimester. Our study shows that in 23 cases, abortion was carried out even before the woman had completed two months of pregnancy. The mean duration of gestation has been determined as 12.4 weeks. In this context it is important to note that the duration of pregnancy is directly related to the reason for abortion. Those who want to go for a sex determination test and then abort have to complete 16 to 20 weeks, which is when ultrasound imaging can detect the sex of the foetus. Those who opt for abortion for reasons of spacing or limiting family size can seek abortion immediately after the pregnancy is confirmed.

The duration of gestation also impacts women's perception of abortion. If the abortion takes place in the first twelve weeks or three months of pregnancy, they refer to it as '*divyatale*', i.e. they do not consider it to be an abortion. Since the foetus is unformed until then, having an abortion in this period is not considered to be a 'killing' or a 'sin'. We were given this explanation by a 45-year-old during an FGD. She also mentioned that:

> It is quite likely that a few women may not have reported the abortion if it was conducted early, because they may not have perceived it as an abortion. They consider it an abortion only after organs are formed.

Quality of Care

Women's concerns and priorities while seeking abortion care are different from those in other health-seeking situations. Factors like 'confidentiality', 'quick service and return' and 'not wanting husband's signature' are given higher priority than safety and quality of care (Ganatra et al. 1998; Gupte et al. 1999). Since in the life of 61 of our respondents, abortion represented a one-time procedure rather than a repeated experience, we assumed that they would remember the services they received at the time of abortion. However, it is possible that if the experience was not too happy, they were reluctant to talk about it, or perhaps they did not expect too much from the health facilities in any case; it could also be that the experience has now become one of minor importance in their lives and they do not feel strongly about it. Whatever the reason, it was difficult to gauge the quality of care they had received from the accounts they gave us.

We tried to collect information about the behaviour of the doctors and the hospital staff from the 29 women

who did not seek abortion in private health facilities. Only 20 of them responded and only one of them described the behaviour of the doctor as 'very bad'; the paramedics' behaviour, on the other hand, was described as 'bad' in three cases. We also asked them about staff competency at the hospital, its cleanliness and the general quality of the services provided. Staff competence was reported as 'bad' in only two cases, whereas cleanliness and services were reported as 'very bad' in only one case. In three instances the response was 'neutral', but in all other cases the women reported positively on the hospital and the doctors.

As mentioned earlier, one woman (35 years) suffered from Cu-T failure and became pregnant. Because she was using the contraceptive device, for four months her pregnancy went unnoticed. When it was realised that she was pregnant, the auxiliary nurse midwife (ANM) from the SC had her admitted to the government hospital in the city. The woman had to spend a week in the hospital, where she was paid no proper attention. No one spoke to her or, despite repeated enquiries, gave her any information regarding her health status. The hospital was also extremely dirty. After the abortion was performed no one came to ask about how she was feeling, even though she had developed complications. The family finally had her transferred to a private hospital, where she received the correct treatment and managed to survive. She is still grateful to the private doctor. While we were interviewing her, she said: '*The poor should die at home and the rich in private hospitals, but nobody should go to a government hospital.*'

Women related horrendous accounts about their experiences at a centre which had advertised its abortion facilities very widely.

> We went there after reading the advertisement. Nurses in the centre beat women and shout at them. We could hear the sound of beating and shouting even outside.
>
> They don't allow the patients to wait there even for half-an-hour after the procedure. They want us to vacate the bed after five minutes. My husband had gone out after the abortion. The nurse told me: 'You find him and just go.' I told her that I was getting *chakkar* (giddiness), but she did not pay any attention.

Surprisingly, a woman who had gone to the PHC for an abortion followed by sterilisation did not seem unhappy. She said: '*Why do we criticise the facilities in government hospital? They give us services. We get cured. What else do we want from them? Of course there were mosquitoes, but don't we have mosquitoes in our homes?*'

Number of Visits and Stay in Hospital

When one decides to have an abortion, one customarily makes at least three visits to the hospital/clinic. The first is for confirmation of pregnancy and blood and urine testing, the second is for the actual abortion procedure, and the third is a post-abortion visit. Data on the number of times women went to the hospital reveal that in 37 instances women had gone there just to get the abortion done. They did not have to make any other visit. The remaining 33 women, however, had made multiple visits.

When the abortion procedure is conducted properly, women are not required to stay in the hospital overnight. In 39 cases, women reported that they had returned home after the abortion on the same evening. However, in cases where abortion was immediately followed by sterilisation, the women had to stay on in the hospital. So did the women who had sought abortion on medical grounds or, as in the Cu-T failure case, had suffered complications after abortion.

Women in both villages had no clue about the methods generally used for performing abortions, not even about the procedure used for their own abortions.

Contraceptive Use after Abortion

In their studies, Ganatra et al. (1999) and Gupte et al. (1997) have mentioned that public abortion services are generally not acceptable because of their insistence on contraceptive use immediately after abortion. Since all the women in our study are currently married and were terminating unwanted pregnancies, they did not have any hassles about accepting contraception. In 38 cases contraception was accepted immediately after abortion (condom: 3, oral pills: 8, intra uterine device [IUD]: 2, female sterilisation: 23, vasectomy: 1, safe period: 1; among the 24 sterilisation cases, 12 were conducted in private hospitals and 12 in government hospitals). One woman underwent hysterectomy and one reported having 'no relations'. Of the four women who gave contraceptive failure (three IUD and one sterilisation) as their reason for abortion, only two have started using contraception. The woman who reported sterilisation failure got herself re-sterilised immediately after the abortion, and one opted for condoms.

Contraception as Condition for Abortion

When women were asked about being compelled to use contraception, only two claimed that they had been coerced. In seven cases, the doctor had suggested contraceptive use and in three cases the women themselves felt that its use was necessary. Of the two cases where contraceptive use was made mandatory, one occurred in a low-cost trust hospital and the other in a private hospital. Both abortions were during the first trimester, which indicates that the decision to abort was taken immediately after pregnancy was detected. The reason for abortion in both cases was: 'completed the desired family size'. Both women had two surviving children, including one son. While coercion is not justified, all these factors suggest that the two women had used some form of contraception even earlier. The woman in the trust hospital got herself sterilised, while the one in the private clinic opted for a Cu-T.

Husband's Consent

When women go to a hospital for abortion, they are often asked to get the signature of the husband as an indication of the latter's consent. In the context of the reproductive rights of women, this has become a vexing issue. Research has shown that the husband's consent is demanded despite the fact that it is not a legal requirement (Gupte et al. 1999; Khan et al. 1996). According to our survey, in 62 cases women mentioned that they were asked for the husband's signature before abortion, whereas in six cases it was not required. We could not get information for the remaining two cases. In most instances (52), the husband had accompanied the woman and could therefore give his signature on the spot. Although a relative's consent is required for surgical procedures and the husband certainly qualifies as a relative, not a single woman in the study area knew that his signature is not required for abortion. But because it is generally demanded, they all felt that it is a legal requirement.

When we discussed this issue with a private doctor in the city, she said:

> It is safer to have the signature of the husband, or another responsible relative, especially when a woman comes for abortion without the husband's knowledge. Because later he can come to the hospital and make a *tamasha* (drama). Who is going to face all that afterwards? We have our work.

Cost of Abortion

We cannot get a holistic understanding of abortion without taking into account the cost of the procedure. Sometimes, when ready cash is not available, women cannot afford to have an abortion. They therefore continue with the pregnancy and end up having an unwanted child. The cost of abortion includes travel expenses, expenses on medicines and the doctor's fees. In our study, 39 women responded by putting a figure to the cost, which varied sharply (Rs 50 to Rs 10,000) from response to response.

The woman who paid Rs 10,000 had sought abortion in a public hospital after conceiving due to Cu-T failure. She had complications and did not get proper care in the public hospital, so she was moved to a private hospital where she had to spend a huge amount. So, even though people opt for public services because of their low cost, they sometimes end up paying much more.

The most frequently reported figure was Rs 3,000. While the overall median cost for abortion worked out to Rs 2,500, it was Rs 3,000 for the private facilities and Rs 1,500 for the public facilities and the abortion centre. The differential in the median cost between abortion in the first trimester (Rs 1,500) and the second trimester (Rs 2,500) is significant.

The abortions included in this study are lifetime abortions and are spread over 17 years—from 1985 to 2002. Given this large time span, the data on costs has to be interpreted cautiously. Five abortions were sought during 1985–92, 10 during 1993–95, 12 between 1996 and 1999, and 10 from 2000 to 2002. The median costs for the four time periods are Rs 1,000, Rs 1,750, Rs 3,000 and Rs 2,750 respectively. Like all other costs, the cost of abortion has also been increasing over time.

The cost of abortion also depends on duration of gestation and, possibly, the reason for abortion. As Gupte et al. (1997) have mentioned, if the abortion is illegal or not within the frame of the Act, then women have to pay more. Such abortions also have to be performed in the private sector. This was confirmed by a young woman of 26 during an FGD in Village Y. She said: '*You throw more money and get anything done in private.*'

Of the 39 abortions for which the costs were reported, 13 were second trimester abortions. In 11 cases the women had to spend over Rs 1,000, while in six cases the cost was little over Rs 3,000. The prenatal sex determination tests mentioned in this study—ultrasound

imaging or amniocentesis—are both second trimester tests, so the abortions performed after them are usually risky. Of the eight women who had aborted their female foetus, six mentioned the costs. In all six cases the charges ranged from over Rs 2,000 to anywhere up to Rs 5,000. Women know that sex-selective abortion is illegal, so they are ready to pay the high charges if the services meet their needs and their perception of quality (Ganatra 2000).

In order to learn a little more about the spending capacity of rural people in general, particularly in relation to abortion, we raised the issue in every FGD. Most participants claimed that the cost of abortion is not very high and well within the householders' capacity to pay. But we did receive two rather peculiar answers:

> *Run kadhoon san* (get the loan and celebrate the festival).

> Abortion is *baljabrichee* Diwali (abortion is a forced Diwali—a festival of lights).

We can conclude, therefore, that abortion is perceived as a necessary evil as far as costs are concerned. The responses seemed to imply that whether one can afford to or not, if an abortion is needed then money has to be spent.

POST-ABORTION

Side-Effects

Abortion, especially in the second trimester, is a risky procedure if not carefully performed. Women may have to face problems like haemorrhage or perforation of the uterus. There is also the possibility of secondary sterility and ectopic pregnancy. We tried to explore whether the women are aware of these potential risks and, if yes, what is the extent of their awareness. Forty-nine women were not aware of any post-abortion problems. Fourteen of them said 'yes, I know', but could not explain what they knew. One woman said 'bleeding', another said 'weakness' and one just said '*tras*' (trouble) if gestation is at an advanced stage. Three women spoke of 'pain in waist' and 'backache', while one said that she knew all about the trouble: '*When I was waiting in the hospital for abortion, I read all the posters on the wall.*' We found that none of them really had any idea of how much trauma an abortion can cause if something goes wrong.

When we asked them about health problems after abortion, 56 women reported no complaints at all. Fourteen did admit to some problems: four reported 'heavy bleeding' and five 'pain in the waist'. One of the women who reported heavy bleeding lives in Village X and is 32 years old. She said that a month after the abortion she started bleeding so heavily that wherever she sat, the floor would become red.

Two women spoke of 'weakness', while another two claimed to have suffered severe problems for which they had to be hospitalised and, as they explained, 'just managed *to survive*'. One reported respiratory problems due to an allergic reaction to a drug during the procedure. This woman, who is 39 years old, had gone to a city hospital to have her abortion done. Just before the procedure, she was given an injection to which she had a severe reaction. She lost her vision, 'got *chakkar*' (giddiness) and then lost consciousness. There was no provision in the hospital to treat her, so she was referred to another hospital where she was admitted into the intensive care unit. After this life-threatening experience, she feels that the decision to abort was a wrong one and that the trauma she suffered was visited on her as a punishment.

But women do seem to have sensed that abortion does cause some form of health problem. One said: '*Abortion mhanje dehachi kharabi (means spoiling the abortion body)*', while another woman wisely remarked: '*Fruit falls down only when it ripens. Abortion is like plucking the raw fruit from the tree. It is of no use to anybody...not to the tree at least. How will it come out without trouble?*'

Feelings and Reactions

Like their reasons, what women feel after abortion is also a complex issue. Two of the most common feelings reported were 'felt bad' (38 women) and 'no feelings' (23 women). Thirteen women said that they had felt 'relief' after abortion. Eight said that they had suffered 'extreme' grief. Almost all of them spoke of the experience as something that they '*had to do . . . there was no other way*'. Three women labelled abortion as murder, where as one felt that it was a criminal act. On the whole, their feelings vacillated between grief and relief:

> I used to cry continuously. Not even eat anything. I was in a really bad state. (23-year-old woman, abortion for female foeticide)

> I had nausea and vomiting all through the pregnancy. I thought I couldn't sustain it this time. Our life is more

important after all. (32-year-old woman, abortion for limiting family)

It was a great relief. Abortion *ani balantpan mhanaje baichya jateecha bhogach mhanava lagel* (abortion and childbirth are a cross that women have to bear). (27-year-old woman, abortion for limiting family)

I did not want an abortion, but could not do anything. I was angry with the doctor. He made the mistake and I had to pay for it. I had to kill my own child. (35-year-old woman, pregnancy with Cu-T)

Felt bad about the abortion, but was happy that another daughter had not come. (34-year old woman, abortion for female foeticide)

I killed my child to save my life. (30-year-old woman, abortion because of prolapsed uterus)

Family Support and Rest after Abortion

When the body is ready for childbirth, and the foetus is healthy and growing properly, to have an abortion is to go against nature. However safe the method, abortion usually ends up creating trauma. Abortion-related morbidity is therefore quite high; and if not performed correctly, it can even lead to mortality.

Traditionally, women rest for at least five weeks after childbirth. Whether women rest after abortion, or are at least advised to so, was another issue that was of interest to us. In 63 cases, women reported that they had been advised rest. In 48 cases the women followed this advice, in 15 they did not. In the remaining cases, there was no such advice. When the procedure was performed successfully, women reported that they rested for a day or two, or they did 'light' housework while others in the house did the 'fetching of water' and 'cooking'. Almost all of them said that since they had to work in the field—where they lift and carry heavy loads—they could not afford to take more than a couple of days off. A large number of women, especially from joint families, said they had received support from their mothers- or sisters-in-law. This support was either mental or moral, or in terms of sharing housework.

Information on when sexual relations were resumed after abortion can indirectly indicate how supportive the husband is. According to 59 women, this period varied from 6 to 90 days. Most of them (49) reported one month and more.

Pregnancies after Abortion

One-third of our respondents, i.e. 24 women, reported having become pregnant after abortion. Of these, 19 had live births, one had a spontaneous abortion and four had induced abortions. Two women were pregnant at the time of the interview. This shows that every time a woman goes in for an abortion, it is not necessarily the pregnancy that is unwanted. It is perhaps the timing of the pregnancy or its outcome that is unfavourable.

Repeat Abortions

Four women in the study reported repeat abortions—three of them twice and one thrice. The woman who has had it thrice is the second wife of a man who has three children by his first wife. The woman's first two abortions were medically indicated. Then she delivered a son. When she conceived yet again, she felt that the family size needed to be limited and sought abortion for a third time. In another case, too, the abortions were medically indicated because the woman suffers from a heart problem. However, she did manage to deliver a son between her two abortions. Irrespective of their health problems, in both cases the women ensured that they had a son before opting for sterilisation. In the other two cases, each of the women already had children—two sons in the case of one woman and one son and a daughter in the case of the other. Both sought abortion because their last child was still too young for them to opt for sterilisation. However, they did get sterilised after their second termination.

Except for temporary weakness and pain, none of the four seemed to be aware of any other problems or consequences associated with repeated abortions. In the FGDs, most women reported weakness and loss of blood. But the men were more precise. In Village Y, one man said: *'It is like a small delivery. It is a loss of her body bakya ugalun gelyasarkhya hota (women get emaciated). They lose their glow.'* In all the FGDs with them, men unanimously said it was all right to have one abortion. According to them, women should not go in for it again and again as it could be dangerous for their health.

Perceptions of Legality of Abortion

It is now 30 years since abortion was legalised in India. We therefore felt that at least the women who had sought abortion would be aware of this. But 24 of the 65 women

did not know whether abortion is legal or illegal. They were not even aware of the issue. Forty-one women did know that abortion is legal, but they did not know the grounds for its legality. Six mentioned that it is allowed only if the foetus is deformed and two said that it is legal if medically advised. However, seven of them were aware that abortion after sex determination is not legally permissible.

There was similar lack of awareness about the permitted period of gestation. When 20 of them said three months and 16 said four months, it seemed like they were guessing based on their own pregnancy and childbirth experiences. Despite living in such close proximity to an urban area, the women had very little knowledge about the provisions of the MTP Act.

A woman from Village X, who already had two daughters, underwent a sex detection test when she conceived for the third time. When the third child was also determined to be a daughter, the husband insisted that she abort the pregnancy. Immediately after the abortion, she got herself sterilised. After relating this to us, she asked: '*Will somebody come and arrest me now because I have undergone sex-selective abortion*?' We can conclude from this that while some awareness about female foeticide has trickled down to them, the other sections of the MTP Act have not. As our FGDs revealed, knowledge of the Act was relatively more precise among adolescent boys and girls than among grown men and women, though even they were not aware of all its nuances.

CONCLUSION

Our research has revealed that women do play a role in decision-making vis-à-vis abortion. We also saw that the majority of husbands are supportive of the women. In most cases, pregnancy is not kept a secret and support from the family, especially the mother-in-law, is often sought. The degree of support the family provides also impacts on the decision to abort, which is taken after much thought because it takes a toll on the mother's health as well as on family finances. Most abortions are sought for spacing children or for limiting family size, though sometimes abortion is also preceded by prenatal sex determination. Other reasons for MTP include medical advice or malformed foetus, the family's financial condition, contraceptive failure and, more rarely, the husband's desire to remarry.

Given the proximity of the study villages to the city of Pune, women can choose from a large range of providers and do not have to resort to the services of traditional healers or quacks. All of them chose to have safe abortions in either private or government health facilities. This did not, however, stop most of them from first trying out home-grown methods to get rid of the foetus.

The majority of the abortions were during the first trimester, with a mean gestation period of 12.4 weeks. The cost of abortion ranged from Rs 50 to Rs 10,000 over the 17-year period. The most commonly reported cost was Rs 3,000, with the median cost in private clinics reported as Rs 3,000 and that in public facilities as Rs 1,500. Women paid more for sex-selective abortions which, being second-trimester, banned procedures, are conducted only in private hospitals or clinics.

Although about 90 per cent of the women had no complaints about their experience in government hospitals, none of them was overly enthusiastic about the doctors and staff, or the facilities they provide. With regard to the abortion centre, women felt that it should be run by a lady doctor and have running water. They also said that the centre should have the necessary medicines readily available.

We found that even among the women who had sought abortion, many do not know that abortion is legal in India. They are not aware that it is illegal either. They do know that abortion of the female foetus is a punishable offence, but not that sex detection itself is illegal and banned. Further, even those who do know that abortion is legal are not aware of the reasons for which it is permitted, nor do they know of the period of gestation in which it is allowed. However, based on their own experience of pregnancy and childbirth, most of them could guess the correct gestation period.

Most women disapprove of abortion and sex detection on moral grounds. Sex detection is acceptable when a family has only daughters and no son. Our FGDs revealed that in the study area, sonography is seen as being synonymous with sex selection.

That the decision on abortion was carefully taken after much thought is reflected in the feelings they experienced after abortion. Though some of them did feel guilty, many felt relief, while some reported that they had no feelings one way or the other. They may not approve of abortion in theory, but most women are practical about it and accept it when they feel they have no other alternative. However, they did say that they do not wish to go through any more abortions 'ever again'.

Recent years have seen the introduction of a new, non-surgical method of abortion—also called medical abortion—that uses oral abortificients (Mifepristone and Misoprostol) and has to be conducted within 56 days of the last menstrual period. Research by Winikoff and his colleagues (1997) reveals that medical abortion techniques are safe and effective, and therefore accessed by many women in developing countries. According to private doctors, many women in India have already started accepting medical abortion and they expect its use to increase significantly, especially in urban areas. The question is: will this factor add to the difficulties in the estimation and understanding of abortions in urban or urban-fringe areas?

RECOMMENDATIONS

- The women in our study could seek safe abortions because they could access abortion facilities easily. Abortion services thus need to be made widely available. This will make women feel less compelled to use unsafe and unhygienic services, particularly if the cost of abortion is also brought down.
- People need to be made aware that abortions should not be used as a method of family planning or spacing between children. Given the unmet need for contraception, dissemination of knowledge about different contraceptive methods needs to be stepped up. The supply of contraceptives also needs to be regularised, so that couples are motivated to use them rather than abortion as a spacing method.
- Women should be made aware of the potential risks of abortion and post-abortion problems. They should be educated about the health hazards, particularly those that impact their reproductive health, posed by repeat abortions. They should also be made to understand that abortions conducted after 20 weeks of pregnancy are risky and unsafe, and should be avoided.
- Apart from legally recognising abortion centres, care must be taken to ensure that they have the equipment necessary to conduct safe abortions, as well as to handle complications or emergencies. Similarly, there should be provision at such centres for some space where women can rest for a few hours—at least until the effects of anaesthesia wear off and the women feel confident enough to go home.
- Information, education and communication activities need to be increased to enhance women's awareness about the legalities of abortion. Among other things, they need to understand that like sex-selective abortion, prenatal sex detection is also a punishable offence.
- As a first step towards eliminating son preference, gender inequalities need to be reduced. Enhancing the status of women would bring down the number of sex selective abortions, which are also hazardous to the health of the mother.

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Sex-Selective Abortion in the States of Gujarat and Haryana

Some Empirical Evidence

LEELA VISARIA

INTRODUCTION

With the passage of the Medical Termination of Pregnancy (MTP) Act, 1971, India became the first country in the world to legalise induced abortions, albeit under certain conditions. The Act clearly specifies not only the reasons for which abortion can be legally performed, but also who can perform it in what sort of facilities.[1] Abortion can be legally availed either if a pregnancy carries the risk of grave physical injury to a woman or endangers her mental health, or when it results from a contraceptive failure or from rape, or is likely to result in the birth of a child with physical or mental abnormalities. Methods to detect deformities in the foetus, such as amniocentesis and sonography, that use ultrasound technology to provide valuable and early information on a range of physical problems, have become widely available in the country, thanks largely to the private medical practitioners who are eager to use newer technologies for diagnosis. However, the technologies that help detect physical or mental abnormalities in the unborn child can also identify the sex of the foetus at no extra cost or effort.

There is increasing indirect evidence from some parts of India that termination of pregnancy is sought not for the reasons stated under the Act but because there is a strong son preference among our people. Modern technology is thus being used to abort foetuses of the unwanted sex. Not surprisingly, female-selective abortions are on the rise.[2] The trends in the juvenile sex ratio, evident from the 1991 and 2001 Censuses of India and the two National Family Health Surveys (NFHS) conducted in 1992–93 and in 1998–99, point to a significant deficit of girl children in the age group 0–6 years (measured as number of female children per 1,000 male children), that has almost steadily increased over time (Miller 1989: 1229–36; IIPS 1995; IIPS and ORC Macro 2000).[3] Between 1991 and 2001, the decline in the juvenile sex ratio was the sharpest in some districts in the states of Haryana, Punjab, Gujarat and Maharashtra. This has given rise to a widespread belief that the practice of sex-selective abortions is becoming widely prevalent and increasing in these areas (Malik 2002).[4]

An analysis of NFHS–2 data on children ever-born five years preceding the survey conducted in 1998–99, undertaken by Arnold, Kishor and Roy (2002: 759–85), indicated that at the all-India level, the male to female sex ratio of the last births was 1,434, which was much higher than the sex ratio of 1,069 of all the earlier births. However, there were significant inter-state variations, with states like Haryana, Punjab and Gujarat manifesting strong son preference in the sex ratio of last births, which ranged between 1,752 and 2,173. This meant that for every 1,000 girls who were last births, there were more than 1,750 boys who were last births. As the authors point out, this is a powerful indicator of the effect

of gender preference on reproductive behaviour. The distortion may be due to the use of sex-selective abortions, which would help rid parents of unwanted daughters, or because parents have decided to stop having children once the minimum desired number of sons are born. In either case, the preference for sons is evident in the behaviour of couples.

However, what has attracted the attention of many women's groups and others is that gender bias is flagrantly aided by a combination of medical technology that helps detect the sex of the foetus, on the one hand, and on the other, the liberal nature of the abortion law which leaves it vulnerable to abuse. The government responded to a petition made by non-governmental organisations (NGOs) and women's groups by passing an Act that prohibits the practice of prenatal diagnosis to determine the sex of the foetus (Prenatal Diagnostic Techniques [PNDT] Act of 1994). Under this Act, individual practitioners, clinics or centres cannot conduct tests to determine the sex of the foetus or inform couples about it. However, despite the existence of monitoring systems both at the state and central levels, and even with the Act having been in place for six to eight years at the time of the 2001 Census, it is fairly evident that in many places the Act has been violated with impunity. The 2001 Census-based juvenile sex ratios show a larger increase in the deficit of girls compared to that prevailing in 1991, particularly in those regions of the country where son preference is historically known to be strong. Since it is easy to hide the link between the two activities—sex detection of the foetus and abortion—particularly if carried out in discrete locations, it is perfectly possible to evade the law in connivance with clinics that have ultrasound facilities and offer sonography. According to the 2001 Census there were 49 districts in India where for every 1,000 male children there were less than 850 female children in the 0–6 age group. The majority, or 38, of these districts were located in just three northern and western states: Punjab, Haryana and Gujarat (Census of India 2001).

Despite evidence showing fairly widespread prevalence of female-selective abortions in these states, our understanding of many issues surrounding this practice at the level of the household, or from the perspective of women who undergo such abortions, is extremely limited. For instance, we do not know enough about what actually compels couples or their families to resort to this practice, who the real decision-makers in the family are, and what impact aborting the female foetus has on the physical or mental health of the woman who typically undergoes abortion in the second trimester of her pregnancy. Our understanding of how the interlinkages of sex-selective abortion and decline in fertility or in the desired number of children are perceived and articulated is also very sketchy. The question often raised is: does the desire for fewer children compel parents to regulate their fertility behaviour in order to produce children of the sex that they want (or that societal norms dictate they should want)?

The present study attempts to explore answers to some of these questions by collecting primary data—both qualitative and quantitative—from women in the two states of Haryana and Gujarat, as well as from a few providers of abortion services in Gujarat.[5]

OBJECTIVES AND RATIONALE

The main objectives and concerns that have guided our research are as follows.

Decision-making process

A woman's fertility is not just a function of her body. It is equally a complex interplay of gender relations that determines her freedom of choice with regard to all issues relating to sexuality and sexual relations. While attempting to understand the practice of sex-selective abortion, the fundamental question before us was: does the woman have any say in the matter of either going through a sex determination test and/or the subsequent abortion, if the foetus she is pregnant with is that of a girl child? We decided to explore this issue by talking to women in groups.

The husband's role and that of other members of the woman's affinal and natal families

The patrilocal structure and formation of households makes a new bride's status in the conjugal family or the family into which she marries very subordinate in the initial years of marriage. This also happens to be the period when childbearing occurs. In this context, we felt it would be interesting to explore whether, even in a situation where choice is limited, a woman has some space to articulate her point of view, or whether, and the extent to which, she accepts and is influenced by the views of the senior members of the family. A related issue that we felt was worth exploring was whether the

natal family or the parents of the woman have any influence on the decision-making process. We also wanted to understand if increase in the level of education makes a difference in the decision-making process, i.e. do educated women enjoy a greater degree of freedom than illiterate women? What are the processes that lead to the final decision of availing abortion services?

Son preference

While the strong preference for sons is well documented not only in India but also in many Asian countries, what needs to be explored and understood is the extent to which the decline in the overall desired or ideal family size affects the desire for sons, and how it influences and impacts the practice of sex-selective abortions (see, for example, Das Gupta and Visaria 1996). Has the desire for fewer children eroded son preference or is it still as strong? If the desire for a given number of sons has remained unaffected, then the implication is that fewer girls are wanted. This issue needs to be understood because it has major policy implications.

Availability of abortion services and role of service providers

While trying to study issues around abortion, it is equally important to understand the various sources that women use for sex-selective abortions, as well as the perspective of the service providers from whom the women obtain these services. It is also necessary to find out how providers view the PNDT Act. If they see it as an imposition that restricts their practice, its violation is likely to continue.

STATE SELECTION

From among the states where the sex ratio of children over time, and especially between 1991 and 2001, has become more unfavourable to girls (Punjab, Haryana, Gujarat and Maharashtra), we decided to undertake this study on determinants of sex-selective abortion in Gujarat and Haryana.[6] Between 1991 and 2001, the number of girls per 1,000 boys aged 0–6 years declined in almost all the districts of Gujarat and Haryana (along with Punjab). Though the magnitude of decline varied, in 13 out of 19 districts in Haryana and 7 out of 24 districts in Gujarat, the decline was of over 5 per cent, or 50 or more per 1,000 children. Census data further revealed that the deficit of girls had assumed alarming proportions in certain districts of these two states.

Both Gujarat and Haryana have witnessed relatively rapid economic development. However, except for a notable increase in female literacy, the fruits of development have not been equally shared between women and men. Historically, the social and health status of women in both these states has been poor. Violence against women is quite widespread; in fact, among all states in the country, Gujarat also enjoys the dubious distinction of recording the highest number of deaths due to burning among women in the prime of their life.

Haryana, along with Punjab, is also historically known to have a more masculine sex ratio, which is usually attributed to the higher mortality that women in this region have experienced from infancy till they are well into their reproductive ages (UNFPA 2001; Yadav 2001). Two significant longitudinal studies undertaken in the Punjab region in the 1950s and 1970s demonstrated that the cultural practice of neglecting female children and delays in provision of health care during illness led to significantly higher mortality among girls compared to boys (Wyon and Gordon 1971; Kielmann et al. 1983: 172–214). A revisit in the 1980s to the Khanna tehsil studied by Wyon and Gordon suggested that the attitudes towards girls and women had hardly changed in the intervening period (Das Gupta 1987: 77–100). Their expression, however, has changed with the development of new technologies that help not only to detect congenital abnormalities in the foetus but also its sex.

Judging by the hoardings in even small towns and the regular advertisements in local newspapers and magazines before the passing of the PNDT Act in 1994, it is evident that clinics conducting sex determination tests had mushroomed in both Punjab and Haryana. While no longer openly advertised, this lucrative practice continues to flourish unabated: it has simply gone underground! The decline in the sex ratio of children in the 0–6 age group in Haryana, from 879 girls per 1,000 boys in 1991 to 820, according to the 2001 Census, suggests that the neglect of female children, including the practice of female abortion, continues to be a cultural norm in the region. The deficit of girls in the child population is even greater in the case of Punjab: from 875 girls per 1,000 boys in 1991, the ratio declined to 793 in 2001.[7]

The decline by 60–83 points in the juvenile sex ratio in a span of just one decade cannot be explained solely

on grounds of the discrimination against girls that has been practised in this region for several decades, because at no other time in the region's history of census-taking has the sex ratio of children declined so drastically. The use of female-selective abortions is almost certainly an added factor. Because of their simplicity and easy availability, and what can only be described as people's lack of moral scruples, these abortions have become very popular and are widely used.

Apart from the contiguous belt comprising Punjab, Himachal Pradesh, Chandigarh, Haryana and Delhi in northwest India, where the juvenile sex ratio reached a level lower than 900 in 2001, Gujarat in western India is another state where between 1991 and 2001 the ratio declined by 50 points from 928 to 878. In this relatively economically developed state, prenatal diagnostic techniques like sonography as well as chorionic biopsy[8] have been available for quite some time through private clinics and nursing homes, even in small towns. Anecdotal evidence suggests that strong competition has led to a reduction in the charges for availing these services, which has worked to the advantage of potential clients. Easy access is, to a certain extent, a response to increasing demand, and, apparently, female foeticide has replaced the old culture of neglect of the girl child, the practice of infanticide among certain communities, and sex differentials in the provision of medical care in the region.

Both Gujarat and Haryana have fairly good road networks with frequent and efficient bus services and well-connected villages and towns. This has increased the mobility of women, who often travel (alone in Gujarat and accompanied by male relatives in Haryana) to nearby towns for various chores, including visits to health providers. There are several private health or medical facilities, even in small towns with a population that is often not more than 30,000. Clearly, they survive and prosper because of the clientele from the surrounding hinterland.

METHODOLOGY

To understand the determinants of sex-selective abortion in Haryana and Gujarat, in each state we purposively selected one district that had the lowest juvenile sex ratio according to the 2001 Census of India. In Haryana, Kurukshetra district had the lowest sex ratio among children aged 0–6 years. In fact, with 770 girls per 1,000 boys, Kurukshetra had the lowest sex ratio among all the 591 districts of the country for which 2001 Census data are available. Within Gujarat, between 1991 and 2001, there was a higher decline in the juvenile sex ratio in the districts of Kheda, Mahesana and Gandhinagar, the latter having been carved out of the adjacent Mahesana and Ahmedabad districts, where historically the practice of female infanticide has been well documented. We selected Mahesana district for the study, which reported the lowest juvenile sex ratio, of 798 girls to 1,000 boys, within the state, according to the 2001 Census.

Within each district, we decided to survey rural areas. Although clinics providing abortion services are generally located in urban areas, the use of these services is also quite high among women living in nearby villages, indicating the efficacy of the demonstration effect. The study is essentially qualitative in nature, undertaken with a view to understand the extent of awareness and use of abortion services by rural women.

From each district, we first selected two talukas or blocks with the lowest juvenile sex ratio, according to the 2001 Census. The talukas selected from Mahesana district were Unja (sex ratio: 744 girls per 1,000 boys) and Vijapur (sex ratio 778). In Kurukshetra the selected talukas were Thanesar (sex ratio: 868) and Pehowa (sex ratio: 865). Information on the percentage of literate women and scheduled castes and tribes in the population, number of households, total population, juvenile sex ratio and distance from the nearest town was compiled for all the villages of the selected talukas. This information was generally based on the 1991 Census, because village-level information from the 2001 Census was not available when the villages were selected. As shown in Table 1, the number of villages in each of the selected talukas varied a great deal. The range in the juvenile sex ratio was also quite wide, even if we do not take into account the outliers at both ends. Generally, juvenile sex ratio does not vary as much as the sex ratio of the total population. The latter can usually be explained in terms of sex-specific migration (usually by adult men in search of work, boys for education or training, etc.), but it is difficult to explain why the sex ratio of children in the 0–6 years age group should vary so much. Such young children would normally be with their parents or move with them. However, it is possible that data error is responsible for some of the observed anomalies.

After listing all the villages in each taluka in descending order of the juvenile sex ratios, we randomly

Table 1: Range in Juvenile Sex Ratio (number of girls Per 1,000 boys) in Selected Talukas in Gujarat and Haryana, 1991 Census

	Total Number of Villages	*Sex Ratio of Rural Population*	*Range in Sex Ratio of 0–6 Population*	*Range in 0–6 Sex Ratio of Bottom Third (Mahesana) or Half (Kurukshetra) of Villages*
Gujarat: Mahesana District	1,093	957		
Unja *taluka*	31	987	1,178–687	865–687
Vijapur *taluka*	56	954	1,416–691	829–691
Haryana:				
*Kurukshetra District**	389	883		
Thanesar *taluka*	281	884	1,563–578	856–578
Pehowa *taluka*	88	880	1,529–564	828–564

Note: *Some of the listed but uninhabited villages have been excluded from consideration in the case of Kurukshetra district.

selected three villages from each taluka. In Gujarat, the selection was made from the bottom third of the villages, such that they were closer to the taluka average on most of the selected indicators, including distance from the nearest town. In Haryana, however, the selection of three villages from each taluka was made from the bottom half of the villages arranged in descending order of the juvenile sex ratio.[9] Thus, a total of six villages from Gujarat and six villages from Haryana formed the universe of our study.

Although the focus of the study was essentially to understand the perspective of women on whether and why they resort to sex determination tests and abort female foetuses, it was felt that a handle on the extent of sex-selective abortions was necessary to understand their motivation more clearly. Therefore, the study attempted to combine the qualitative approach with some quantitative information. We obtained the latter by listing all the households in the selected villages and collecting information on the pregnancy history of all currently married women between 15 and 49 years in those households. The schedule designed to collect this information was quite short and, apart from some socio-economic background information, no additional questions were asked. While collecting information on the outcome of each pregnancy that the woman goes through, provision was made to record all possible outcomes, including spontaneous or induced abortions. However, in spite of giving intensive training to the field investigators to record all events, analysis of data indicated under-reporting of abortions.

Focus group discussions (FGDs) conducted with women belonging to different socio-economic strata within each village constituted the qualitative component of the study. The number of FGDs varied between villages; in multi-caste villages FGDs were conducted with most of the numerically significant groups. As shown in Table 2, in all, 28 FGDs were conducted in the six villages of Mahesana district in Gujarat, and 16 in the six villages of Kurukshetra district in Haryana. The total number of women who participated in the discussions was 298 in Gujarat and 135 in Haryana. On an average, three to four FGDs were conducted in each village, keeping in mind the caste composition of the population. Since the two sets of data complement each other, the report has integrated them and is based on an analysis of both sets of data.

All the research tools were prepared in both Gujarati and Hindi—the languages of the field areas. Also, two independent teams were constituted to do the fieldwork in Gujarat and Haryana. Knowledge of the local language and its nuances was very important to probe into

Table 2: Profile of Women Who Participated in Focus Group Discussions in Gujarat and Haryana

	Mahesana	*Kurukshetra*
Number of focus group discussions	28	16
Total number of women participants	298	135
Average age of women	29.5	31.4
Caste composition of women (%)	100	100
High castes	32	49
Other backward castes	53	25*
Scheduled castes	15	26
% of literate women	59	41

Note: * Includes one Muslim and nine women whose caste names as recorded by the investigators made it difficult to identify the category in which they would fall.

this sensitive area. The principal investigator provided orientation and training, including a discussion on ethical issues, to both teams.[10] Each team consisted of three field investigators and a supervisor. The quantitative data were edited in the field but their computerisation and analysis was done at the Gujarat Institute of Development Research in Ahmedabad. The notes taken during focus group discussions were expanded at the two centres and reports based on them were prepared independently. Thus, while the general issues pertaining to the two states are discussed together, state-specific substantive findings are presented and discussed separately.

The research tools were pre-tested in the field and later modified in the light of feedback received. When we visited the area before the actual field investigation started, we learnt that when the districts were being bifurcated in Gujarat, the boundaries of some the villages had also undergone changes. We therefore had to consult local officials to identify their revised boundaries.

ETHICAL CONCERNS

Given the sensitive nature of the issues that formed our inquiry, the ethical concerns related to conducting the study were addressed right in the beginning. First, a project-specific ethics committee was constituted with the principal investigator as a member. Other members included people from the NGO community, a lawyer and a gynaecologist. The director of a well-established NGO was appointed as the convener. An initial meeting apprised the committee members of the purpose, objectives and methodology of the study, and the suggestions they gave were incorporated into the design of the research tools. It was agreed that, initially, community leaders would be contacted and informed about the purpose of the study. When the draft of the consent letter for FGDs was shared with the committee members, the overwhelming response was that it should be written in easy-to-understand language. The issue of obtaining the signature of the respondent on the consent letter was discussed and it was finally decided that oral consent should be treated as consent if any respondent was unwilling to sign the letter. Similarly, it was emphasised that any question that may require identification of individuals should be deleted from the house-listing schedule as well as from the interview guide.

The orientation given to the field investigators emphasised the importance of privacy, confidentiality and respect for the woman's right to withdraw at any stage of the interview or discussion. It was also emphasised that while it was all right to obtain information on household characteristics from any adult member of the household, pregnancy history could be obtained only from the women themselves. And, further, that care would be taken to ensure that this information was not collected in the presence of other family members, unless the respondent woman had no objection to it. In addition, investigators would have to reassure all respondents that the information provided by them would be used for research purposes only and not be shared with anyone else. Nor would their identity, under any circumstances, be revealed to anyone within the family or to any member of the community or village.

Our field experience indicated that written consent was difficult to obtain.[11] For some reason, putting their signature on a piece of paper, even though it was agreed that a copy along with the name, address and telephone number of the member-convener of the ethics committee would be left with them, was unacceptable to most respondents. We also found it difficult to keep their attention from wandering when the page-long consent letter was read out. We therefore had to make two compromises. One, we had to convey the content of the letter to the respondents orally. Two, we had to accept the oral consent given by most of the respondents for participating in the study.

A major issue that came up in Gujarat was the awareness among women that some abortions (meaning the sex-selective variety) were illegal and they feared that if they revealed the information, it would put the doctor who performed the abortion in a difficult situation. Even though we did not insist on knowing the sex of the aborted foetus, the respondent women tended to hold back on the number of abortions they had undergone. We did not always succeed in convincing them that no information provided by them would be shared with anyone else, or that we were not in a position to take any action against anyone.

PROFILE OF WOMEN IN THE TWO STATES

As mentioned earlier, in all the six villages selected from each state, efforts were made to collect household-level information and the pregnancy history of all currently married women in all households.[12] Some of the

Table 3: Profile of Women Interviewed in Gujarat and Haryana

Characteristics	*Gujarat*		*Haryana*	
	Distribution	*Av. No. of Live births*	*Distribution*	*Av. No. of Live births*
No. of currently married women	1,388	2.9	1121	3.0
Age of women (%)				
< 20	9.1	10.8		
21-24	17.1	1.9	15.3	1.8
25-29	22.7	21.4		
30-34	20.3	2.9	18.5	2.8
35-39	18.3	16.8		
40 +	12.5	3.6	17.2	3.9
All ages	100.0		100.0	
Education				
Illiterate	47.6	3.5	44.2	3.5
Primary level (Class IV)	10.9	2.8	3.3	2.6
Upper primary level (Class VIII)	22.5	2.5	39.5	2.5
Above upper primary level	19.0	2.0	13.0	1.8
All	100.0		100.0	
Occupation				
Cultivator-cum-animal Husbandry	30.4	2.8	0.3	4.3
Agriculture/manual labour	33.7	3.4	29.7	3.7
Other misc. economic activity	3.1	3.0	1.5	2.8
Housework	32.8	2.5	68.5	2.7
All	100.0		100.0	
Caste composition				
Upper caste	38.8	2.3	42.1	2.6
Other backward castes	53.2	3.3	28.1	3.2
Scheduled caste	7.1	29.6		
Scheduled tribe	0.8	3.3	0.2	3.6
All	100.0		100.0	
Household type				
Joint	33.8	2.5	44.4	2.6
Nuclear	66.2	3.2	55.6	3.4
% of households owning land	57.0	2.7	38.7	2.5
Not owning land	43.0	3.2	61.3	3.4
Average number of children born per woman		2.9		3.0
Sex ratio of live births (no. of females per 1,000 males among all parity children)	843		855	

salient characteristics of these women are presented in Table 3. The information was collected as part of our house-listing exercise and is thus very limited in scope. Only a few questions, such as current age, age at marriage, education, activity, caste and ownership of land, were asked. The information provided by the women was rarely probed, but was used to identify women for focus group discussions in each village. Although the primary focus of the research was to gain an in-depth understanding of such issues as the decision-making process relating to abortion and son preference by using the qualitative approach, it was felt that a detailed pregnancy history of the women would give us an opportunity to indirectly estimate the extent of sex-selec-

tive abortions in the two areas and get a quantitative handle on the characteristics of women who have used this practice.

There were clearly certain differences between the two regions, especially in terms of educational attainment and activity status of women, and in terms of caste composition, household type and ownership of land. However, we did not place too much emphasis on them because of the distinct possibility that had some of the questions during the house-listing been posed differently, we might have elicited different responses. It was also possible that some of the responses were interpreted or coded differently in the two regions. Be that as it may, close to half the women in both Gujarat and Haryana reported themselves as being illiterate, although during discussions with field investigators it emerged that when young, some of them had been enrolled in schools for two or three or more years. However, their reading and writing skills were either rusted or were rarely used after leaving school, such that they had virtually relapsed into illiteracy. Some of the women therefore felt that it was not worth reporting their level of formal education, which was in any case minimal. And since they had not acquired any literacy skills, they were for all practical purposes illiterate. All the same, the percentage of women with education beyond the lower primary level in the Haryana villages (52.5) was higher than that in Gujarat (41.5).

As far as women's activity is concerned, the two regions differed substantially. In our field area in Haryana, more than two-thirds of the women reported household work as their primary activity. Clearly, some of the work women do as unpaid family workers, including taking care of cattle or milch animals, is not perceived as economic activity but as part of their domestic duties.[13] In Gujarat, on the other hand, only a third of the women said they were not engaged in any economic activity. Animal husbandry was reported as the major activity in which a third of the women were engaged.

Another important difference between the two states is in caste composition. In the Gujarat villages, economically and socially backward communities (known as other backward castes or OBCs) constituted more than half of the population, while scheduled castes constituted only 7 per cent of total population; in the Haryana villages on the other hand, scheduled castes accounted for 30 per cent of the population, while OBCs accounted for 28 per cent. The upper castes are a residual category and accounted for about two-fifths of the population in both survey areas.

The average number of live births to women in both the states follows a pattern observed in many surveys. The average number in both the states was estimated to be 2.9–3.0 children per woman. Illiterate women had, on average, 50 per cent more children, compared to women who were educated beyond the upper primary level.[14] This differential was also observed with regard to other variables such as caste, landownership and activity status of women. Women belonging to upper castes or landed households had, on average, one child less than those who belonged to lower castes or landless households. The pattern observed among the better-off in society has implications for and linkages with the sex composition of the few children that they have or desire.

However, for our study, the interesting finding was that not only was the average number of children born to the women almost the same in both states, but that the sex ratio of all live births to the women was also very similar. The number of girls per 1,000 boys was 843 in the case of Gujarat, and 855 in the case of Haryana.[15]

DEFICIT OF FEMALE CHILDREN

As has been mentioned earlier, the investigators were instructed to record all pregnancies and their outcomes, including the sex of the live births. However, the pregnancy histories collected by them show that a very small percentage of pregnancies resulted in abortion. (In both Gujarat and Haryana, induced and spontaneous abortions together accounted for just about 7 per cent of all pregnancies.) As has been observed in most other studies, including NFHS surveys, women's reluctance to report an abortion is evident in our study as well. However, we tried to ascertain the practice indirectly by calculating the sex ratio of all live births by the birth order as well as the sex ratio of the last birth occurring to all women. The results for Gujarat are presented in Table 4 and for Haryana in Table 5. The sex ratios have been calculated based on the background characteristics of women, such as age, level of education, work status, caste and whether the family owns land. (Information on husband's education and work status is not shown in the tables.)

A noteworthy finding for Gujarat (Table 4) was that, overall, preponderance of male children or deficit of girls increased as the birth order increased. Although

Table 4: Sex Ratio of Births by Birth Order and Background Characteristics of Women Surveyed in Gujarat Villages

Characteristics	Sex Ratio of All Live Births	Sex Ratio of 1st Live Birth	Sex Ratio of 2nd Live Birth	Sex Ratio of 3rd Live Birth Births	Sex Ratio of 4th and Higher Order	Sex Ratio of the Last Birth	Total No. of Live Births
All							
Age of women	*844*	*867*	*853*	*849*	*780*	*479*	*3708*
15–24	927	882	916	1,098*	1,072	732	527
25–34	860	983	841	722	824	460	1,704
35 +	799	716	839	973	730	353	1,477
Women's education							
Illiterate	900	892	993	947	783	557	2,128
Primary level	824	698	838	1,143*	788	611	405
Upper primary level	767	887	707	562	944	366	721
Above upper primary level	742	893	659	618	286	360	454
Women's activity							
Cultivator-cum-animal husbandry	747	769	822	769	539	421	1,101
Agriculture/manual labour	931	891	926	949	972	598	1.481
Other misc. economic activity*	967	1,053	1,000	1100	714	360	118
Housework	820	928	787	772	667	431	1,008
Caste composition							
Upper caste	727	838	654	978	588	358	1,065
Other backward castes	886	883	952	935	773	565	2,306
SC + ST	971	889	1,143	769	1,138	524	337
Landownership							
Yes	800	874	778	824	642	409	1,898
No	893	857	956	881	887	578	1,890
No. of births	3,708	1274	1074	696	664		

Note: * The number of women with these characteristics was very few in the total universe and therefore the estimated sex ratios based on a few cases cannot be accepted as stable.

the sex ratio of the first birth was greater than the normally acceptable range of 104–107 boys per 100 girls, by the time women had their fourth or higher parity child, the chances of it being female diminished greatly. Assuming that the sex ratio at birth (without any interventions) was around 950 girls per 1,000 boys, the deficit of girls increased to almost 25 per cent.

However, this overall picture masks some of the significant and larger differences by certain characteristics of women. For example, the deficit of girls among the second and third child was much greater for women who were educated beyond primary level, women who were not engaged in any economic activity or who reported themselves as housewives, women who belonged to upper castes and those whose families were landed. The high correlation between these variables suggests that in Mahesana district women who belong to the upper castes, such as Chaudhury Patel, tend to be more educated than women from the other communities. In addition, their households are landed and they do not participate in any economic activity outside their home. Until almost the 1970s, there was no tradition of sending girls to school among the Patels of Mahesana, but this has changed in the past two or three decades. Partly in response to the demand among educated boys for educated brides, Mahesana Patels have started educating their girls. The overall assertion made by many that the sex ratio is much more adverse for females among the economically better-off population groups in relation to others does indeed hold true for our study.

The number of fourth and higher order births were fewer, but by then the socio-economic differentials in the sex ratio of these births are of considerably less significance, implying that many women, regardless of their level of education, caste or economic status, ensured that they produced sons.

Table 5: Sex Ratio of Births by Birth Order and Background Characteristics of Women Surveyed in Haryana Villages

Characteristics	*Sex Ratio of All Live Births*	*Sex Ratio of 1st Live Birth*	*Sex Ratio of 2nd Live Birth*	*Sex Ratio of 3rd Live Birth*	*Sex Ratio of 4th and Higher Order Births*	*Sex Ratio of the Last Birth*	*Total No. of Live Births*
All							
Age of women	*853*	*951*	*824*	*829*	*774*	553	*3,030*
15–24	863	1,020	742	560	800	755	382
25–34	836	962	833	716	716	434	1,228
35 +	868	935	848	859	824	385	1,420
Women's education							
Illiterate	870	903	883	906	782	483	2,006
Primary level#	852	—	—	—	—	500	52
Upper primary level	815	1,168	649	482	947	404	787
Above upper primary level	854	887	934	583	—	614	185
*Women's activity**							
Agriculture/manual labour	889	904	907	990	775	576	971
Housework	839	978	813	700	761	420	1,591
Caste composition							
Upper caste	801	973	792	571	686	414	1,200
Other backward castes	853	867	778	918	873	612	889
SC + ST	926	1,067	935	903	789	443	966
Landownership							
Yes	815	980	786	573	782	415	1,089
No	876	970	858	882	773	503	1,942
No. of births	3,030						

Notes: # In Haryana there were a total of only 50 births to women whose level of education was up to primary level. As shown in Table 3, women in Haryana who enter the school system, continue to pursue education beyond primary level. As a result, no stable estimates of sex ratio by birth order for women with primary level education are possible.

* The number of women in the categories of cultivators-cum-animal husbandry and other miscellaneous activities was very small and hence the sex ratios of the children of these few women are not estimated.

The situation in Haryana is very similar to that observed in Gujarat. Sex-selective abortion during the first pregnancy did not appear to be the norm and was not practised, but by the time women had their second or third child, almost 50 per cent more boys were born compared to girls. This preponderance of males or deficit of girls was observed more among women who were better educated, belonged to higher castes and whose families were landed. As in Gujarat, these women belonged to the dominant Chaudhury caste. Interestingly, the Chaudhury Patels of Mahesana district informed us that about 200 years ago, they had migrated in this region from Haryana, bringing with them some of their social practices and customs that are current even today. The similarity between the two groups where treatment of women is concerned is also striking. The practice of female infanticide has been known to exist in both groups, and with the advent of new technology this inhuman practice has apparently been replaced by sex-selective abortion.

The focus group discussions that were conducted with women belonging to diverse socio-economic and educational groups corroborated these findings. Their reasoning about the sex composition of the children was articulated as follows: the majority of women accept the outcome of the first pregnancy—regardless of whether it is a boy or a girl. However, if the first child is a daughter, upper-caste women are overtly or covertly pressured to take appropriate measures for ensuring that the second and/or third child is a boy. Although this pressure is much less among the lower castes, many among them have started either emulating the women from the upper castes or have started thinking the same way. We discuss the emerging trends as evident from the qualitative component of the study in a later section.

Sex Ratio of Last Births

Tables 4 and 5 also show the estimated sex ratios of the last live births that occurred to all women in both states. These estimates relate to all women and not just women who have completed their childbearing. It is quite likely that some of these women will go on to have more children. However, it is evident that the sex ratio of last births had a greater deficit of girls than the sex ratio of all other births. There were less than half as many girls as boys among the last births for most groups of women. The ratio was most skewed among women who belonged to upper castes, whose families were landed, who had some education and were older in age. Among these women, for every 100 boys that were last births, there were only around 40 girls that were last births. This suggests that if the last birth is that of a boy, couples who have attained their desired number of sons refrain from having another child. But if the last conception or birth is that of a girl (who may be allowed to be born or aborted), they continue bear children until a son is produced. This is a rather powerful indicator of the effect of gender preference on reproductive behaviour. The analysis of the NFHS–2 data for women who had completed their childbearing showed a very similar trend. At the all-India level, the sex ratio of last births (143.4 boys per 100 girls [or 70 girls per 100 boys]) was greatly in favour of boys, compared to the sex ratio of all other births (106.9). The same pattern was observed in every state but was very pronounced in the western Indian states of Haryana and Punjab, where the sex ratio of last births was 188 boys per 100 girls compared to 103 for all other births (Arnold, Kishor and Roy 2002).

Son Preference

Son preference was very evident among all social groups in both Gujarat and Haryana, even though the desired number of children had come down to two or three. During the FGDs, none of the women said that she wanted more than two or three children. They came up with fairly rational explanations about why many children are not desirable in the present context, indicating that the small family norm has spread across all groups and is accepted widely. Women also indicated that they have seen advertisements on the advantages of small family size on television and heard about them from health providers who visit their areas. As one upper-caste woman in Gujarat said:

> Things have become so expensive. It is necessary to take proper care of the children. If we have two children, we can take care of them properly. If we have more children, then we can't take care of them properly. Therefore, we should have less number of children so as to manage things properly. We can provide good clothes to them, good food to them, and good education to them.

Similarly, a woman in Haryana said:

> There is hardly anybody today who wants a family of ten! Everybody wants a *chhota parivar, sukhi parivar* (small family, happy family). If we have a small family, we would be able to manage with our limited resources in terms of agricultural land.

However, in spite of wanting fewer children, the women were quite clear about their choice of sex for these children. Their responses revealed a very widespread and open acceptance of son preference. In order to filter out the influence of other family members on the women's choice, we asked them to imagine a hypothetical situation wherein they had complete freedom to choose the number and the sex composition of their children. Among those who indicated a preference for three children, the overwhelming response was for two sons and one daughter. However, some women who wanted to limit the family size to two children indicated that they would want at least one of them to be a son. If, however, the two children turned out to be girls, they would almost certainly opt for a third child in the hope that it would be a boy. Though women did admit that not all sons support parents in their old age, the desire for sons was nevertheless very strong among women of all social groups. As a woman from a backward community in Gujarat put it:

> Yes, we wait for the son. We must have a son, howsoever he may turn out to be. We would always hope for a son. After all, the daughter will go away after her marriage. The son will stay with us and take care of us.

Women from the upper castes (Chaudhury in Haryana and Chaudhury Patel in Gujarat), which practise dowry, even said that if the first child born to them is a boy, then they would be satisfied with just one child. The menace of the dowry system is a strong deterrent to having girls, along with the fear that the daughter may be sent back to the parental home if her in-laws are not

satisfied with her dowry or for any other reason. According to these upper-caste women (in both states), giving gifts, money, etc., to daughters is a lifelong activity, which is in addition to the large cash payment in dowry to the groom's family at the time of marriage. On almost every important occasion (birth of a child, birth of a son, marriage, death of close members of the affinal family), the daughter is given something appropriate to mark the occasion. The dowry payment to the groom's family varies depending on many factors, such as the economic status of the dowry givers as well as receivers, and the educational attainment and employment status of the groom. Factors such as age and looks of the girl are also considerations that are taken into account in determining the amount of dowry. In spite of all this, the fear that the girl may be sent back by the in-laws or her husband on some pretext or the other looms large in the minds of many mothers.

> There is trouble for daughters. They may find a good family or a bad family after their marriage. The times are not good. They [the daughters] may come back home. If they have trouble with their in-laws, they may be sent back by their in-laws. In earlier times, the women used to do backbreaking labour, look after the cattle after their marriage. These days they don't do that. If there is an economic problem, the in-laws just send the bride back to her parental home. So a girl is always a reason for tension in her parents. (Patel woman from Gujarat)

> A girl requires a dowry if she is to be married, which is a cause for anxiety. Finding a suitable groom and hoping that she will settle down happily in her new home is a source of worry. (Woman from Haryana)

On the other hand, although women from backward communities and scheduled castes also indicated a preference for small family size, their willingness to modify their behaviour in the light of the sex of the children born to them appeared greater than among the higher-caste women. For example:

> Although three children are enough, if two of them are daughters then we must have another [one more] son. It is like that in our Thakore community. Because if something untoward happens to one son, then at least we should be left with another one who would continue the family tree. In our community, if you have only one son and he dies, what do we do? The upper-caste people can afford that. We can't. The upper-caste people go for only two children—one son and a daughter.
>
> People prefer more sons because the daughter goes off to another family after marriage. There are hopes with regard to the son that he will get married, bring a bride and look after us during our old age. The daughter will go to her in-laws after the marriage. Some may be lucky to get a good family; some may not be as lucky.

SEX DETERMINATION

As is evident from the sex ratio of live births presented earlier, the almost universal desire for more sons than daughters does find expression in actual behaviour. In the FGDs, women from all communities categorically indicated that if the first-born child is a daughter, then the couples do want to know and take steps to find out the sex of the next child. All women who participated in the discussions knew exactly where to go for sex determination tests, how much they cost, and so on. They were aware that such tests are not done in public hospitals but in private facilities, the majority of which also provide abortion services. The women could also describe the sex determination procedure quite accurately and in great detail.

The women participating in the FGDs also indicated that when they become pregnant again after the birth of a daughter, there is some pressure from the elders in the family to ensure that the next child is a boy. At the same time, the desire for producing a son came across as very strong among the women themselves. There is clearly a deep internalisation of patriarchal values, which appears to be linked to their sense of security. By and large, however, both husband and wife take the decision for a sex determination test. The higher-caste women also reported that they don't even have to inform the family elder about the test.

During discussions, we asked the women whether, if they had the freedom to do so, they would decide to go for the sex determination test on their own. Son preference appears to have been internalised to such an extent that women had no hesitation in saying that they would want to know the sex of the foetus if they already had one daughter. They see nothing wrong with wanting to know the sex of the foetus, although almost all of them have to consult the husband and/or get his permission (partly because of the cost involved).

> We have to go for the test if the first child is a girl. If we don't go for the test, we may end up giving birth to three daughters in the false hope of getting a son. (Kshatriya woman in Gujarat)

> Women definitely get the test done . . . if it is a girl they abort the foetus and if it is a boy, they keep the baby. Everybody knows about the test . . . the women themselves want to know whether they are carrying a male or a female child. (Chaudhury woman in Haryana)

The women from the backward communities had an added consideration for obtaining the consent of the husband before going in for a sex determination test. When asked whether they can go for the test without getting their husband's permission, the general response was:

> No, we can't go alone. We can't go without asking the husband. The husband might say that she wants to keep the child, or that the child may be from someone else and therefore she is going alone. So we can't even step out of the house without asking him.

Although the parents or the in-laws of the women might have produced several children, it appears that they do not wish a similar fate on their sons and daughters-in-law. As the women explained, since the facilities (for sex determination and abortion) did not exist in earlier times, the parents had no choice but to have several children. Now they, especially the mothers-in-law, themselves suggest that their daughters-in-law get the test done, especially if they have already produced one or more daughters.

> Mothers-in-law also have changed with the time. They are also aware of the price rise. They might have had raised their children, but it is difficult to raise more children today. (Backward-caste woman)

> If we already have one son and one daughter, the in-laws ask us to go in for a test and if the test reveals the foetus to be a daughter, they even ask us to go in for abortion. (Chaudhury Patel woman)

At the same time, some women living in nuclear families indicated that they did not always have to consult other family members for the test. It also emerged from the discussions with women that the decision about and the visit to the clinic for sex detection were usually kept secret by the husband and wife. They would go to the nearby town on the pretext of shopping or visiting relatives and get the test done, with no one in the family any the wiser.

> No one in the family would know, not even the elders. We would tell them that we are visiting our parental house, board a bus, get the test done and return. No one in the family except the two of us would know. In the present situation, no one in the family needs to know anything about this. They only know that we are on a visit to our parental house. The husband reaches the hospital on his own. We get the test done, and if need be, even have abortion performed, and return home as if nothing has happened. (Patel woman in Gujarat)

During the FGDs, we also asked women whether they informed or consulted their own parents or other members of the natal family about the test. Usually, given India's patriarchal society, once a girl is married, her parents have practically no influence in their daughter's life. In every single group discussion women indicated that their parents had no say whatsoever in the matter. However, some of the women did say that, knowing how much their daughters' well-being and status in the in-law's family depended on their ability to bear sons, the parents want them to produce at least one son and therefore pray to god to bestow a son on them.

> The parents do not say anything. Only the in-laws express their preference about having sons. But our parents would want that their daughter should have a son. If she has one son, then she should have another too. For this, they would also offer prayers. (Backward-caste woman in Gujarat)

Decision-making Process about Female-selective Abortion

We also asked the women about the decision-making process if the foetus is found to be female. According to them, if a woman has already given birth to one or two girls but has no son and was again pregnant, then everyone in the extended affinal family asks her directly or indirectly to get the sex of the foetus detected. The Chaudhury Patel and other high-caste women almost uniformly reported this practice. Women of some of the lower castes indicated that aborting any foetus is a sinful act and, therefore, the question of sex detection and subsequent abortion is unwarranted.

However, since the test is done in the second trimes-

ter, the act of abortion if the foetus is female is usually known in the family. The elders generally approve of the couple's decision or give it their tacit consent. If, however, the couple want an abortion in the first trimester regardless of the sex of the foetus, then the abortion is often performed without the knowledge of others. Women also indicated that the decision to abort the female foetus is almost entirely that of their husbands and/or mothers-in-law. By themselves, women cannot take this decision. At the same time, the women hardly expressed or conveyed any remorse about aborting female foetuses. Since women have virtually no decision-making power, they accept whatever their conjugal families, including husbands, want. They simply go along with the decision made for them by others. But we could see some differences between women belonging to higher social groups and those who belonged to scheduled castes and other backward communities with regard to the influence of in-laws in these matters. The high-caste women had to inform and consult their in-laws, while the lower-caste women had to obtain only their husbands' consent for abortion. Since a large proportion of the latter tended to live in nuclear settings, this could be one reason for the low involvement of their extended families in decisions pertaining to their lives.

> A woman cannot take a decision on abortion on her own. If the husband does not want a daughter, then he would ask us to go in for abortion. And if we want a daughter, then we keep the daughter. If the husband is ready to support us and stand by us, we can be firm and go for abortion or not go for abortion. In any case we need to consult our husbands. (Patel woman)

> There is no such pressure to abort female child from the family. Only the wish of the husband prevails, no one else's. Even if other members of the family say that they do not want a girl but the husband wants to have a daughter, then he has his way. Similarly, if the family members want the child but the husband does not, then we have to go for abortion. (Woman from a potter community)

Women also reported that sometimes they themselves want to abort a female foetus because they already have one or two daughters. This feeling was stronger among women belonging to social groups like the Patels and Kshatriyas, who value sons much more than daughters. They unhesitatingly indicated that they would opt for abortion. But even in such cases, they would have to obtain the permission or consent of the family elders to exercise their wish.

> If the first two children are girls and the third one is also a girl, then we need to take the permission of the elders to go in for abortion. We have to follow the advice of the elders.

> We would decide to go in for abortion if we find out that it is a girl child. What can the husband say? He would also advise us to go for abortion. If we already have a girl, then why should we go for another girl or collect many girls? The family members exert pressure only when we have girls. But mostly, women themselves realise that they already have daughters, so they should go for abortion on their own.

SERVICE PROVIDERS

The majority of respondents in both states knew which towns had private doctors with nursing or maternity homes that provided sex determination and abortion services. They were also familiar with the prevailing rates for sex determination tests and abortions. Surprisingly, there was very little variation in the information provided between the two states and, within the states, between social groups. However, the awareness about the legal status of sex determination tests was greater in Haryana than in Gujarat. The Haryanvi women, therefore, get the sex determination test done at one place and abortion at another place, without disclosing the fact that they have undergone the test and that they know the sex of the foetus. They also indicated that although the doctors are not supposed to tell them whether the foetus is that of a boy or a girl, *'it is still going on'*—meaning that they do inform the women.

Based on the information provided by the women in Gujarat, we decided to contact a few private practitioners in the towns around the surveyed villages. Since we had provided them with the consent letter beforehand, clearly indicating that they were under no obligation to participate in the study, we were pleasantly surprised to find that all eight doctors whom we contacted in one town and one village of Mahesana district were willing to talk to the research team. We were also very surprised to learn that in Mahesana town, which has a population of 31,000 according to the 2001 Census, there were nine

maternity homes with an average of ten beds, and all of them had ultrasound facilities and did sonographic tests.[16] Understandably, women from the nearby villages used these facilities not only for delivering children but also for the other services offered. All the nursing homes had very prominently displayed notice-boards—one indicating that abortion services were available at the facility, and another proclaiming that information on the sex of the foetus would not be provided, nor would requests for such information be entertained.

The majority of doctors belonged to the upper castes and came from the same area. They therefore had a good understanding of the social customs, norms and economic profile of the area. All except one doctor owned an ultrasound machine, but indicated that they no longer carried out sex determination tests and used the machines to detect abnormalities in the foetus. A notice declaring that sex determination tests, which are against the law and a cognisable offence, are not done in their clinic was prominently displayed in their nursing homes. All the same, they indirectly indicated that while they themselves were not doing these tests, other doctors in the area could well be doing them since the demand for such tests is very high, especially among the higher castes and among those from the lower castes who already have two or three daughters.

The doctors confirmed our impression based on the FGDs and the indirect estimations of the use of female foeticide, and said that son preference continues to be very strong in the region. At least one son is a must and almost all couples, regardless of caste, do not desire more than one daughter. They also indicated that the pressure on women of the Patel community to determine the sex of all pregnancies, including the first one, is quite high. However, women from other caste groups do not experience such pressure for the first child.

All the doctors were aware of the PNDT Act and its ramifications, as well as of the consequences of aborting female foetuses. Some of them indicated that the PNDT Act should be implemented very strictly and violators should be punished. However, one doctor, who was more candid than the others, said that while all of them may not admit to it, most doctors, including himself, in the region performed the tests in their clinics. When there is a high demand for a service and providing it would fetch good returns, not many people would be able to resist the temptation. He also said:

> If I do not do the test, the patient would go to someone else. Also, patients who come to me for other services will also stop coming. That will have a direct adverse effect on my work and income.

CONCLUSION

The in-depth focus group discussions with women from all social groups in both Gujarat and Haryana have clearly brought home some hard-hitting truths. One, there is a collusion between cultural or social norms and technology, that is all-pervasive. Son preference is so strongly entrenched, and the well-being and status of girls so precarious once they are married, that couples tend to avoid having girls. Facilities for conducting sex detection tests with ultrasound machines proliferated in both states some 15–18 years ago and are now even found in some of the relatively large villages.

Two, despite the spread of schooling among girls in both these areas in recent decades, the patriarchal social structure continues to survive. Women derive value and position only as mothers of sons. Their happiness and social status in their conjugal homes is thus dependent on producing sons. Women themselves have internalised these values to such an extent that even when they say that daughters take better care of parents in old age or are more emotionally attached to the mothers, their statements sound hollow because, in spite of such feelings, more sons than daughters are desired. In the pursuit of sons, they have become, with some pressure from their families, consumers of the new ultrasound technology that allows them to bear only sons.

Three, the shift to a small family size, evident in India in recent decades, has not been accompanied by a simultaneous shift in the economic and social pressures to have sons and avoid daughters. As was stated by women in both states, they want fewer children but only if at least one, if not two, of those children is a son. This has led to increased acceptance and use of sex-selection tests to achieve the parental preference to have sons while not exceeding the desired number of children.

However, the awareness about sex determination tests being illegal was fairly widespread among the women in our study area. In another study conducted in a town in Maharashtra, 14 per cent of women, 18 per cent of their husbands and 28 per cent of the married men felt that women should be able to have an abortion if the foetus is female (Clark et al. 2001). Many of our res-

pondents also felt that the ban should be removed and couples should have the freedom to decide the sex composition of their children. At the same time, they were also aware that the requisite services are easily accessible from private providers. Government legislation against the use of ultrasound technology for sex detection has only driven it underground and raised its cost, but it is extensively available and used for sex detection. However, the charges are still within affordable limits and, in any case, as many respondents pointed out, the cost of the test and related abortion is much lower than the cost of providing a dowry and the other monetary obligations that are due to a daughter after marriage. As one of our researchers pointed out:

> The alarm bells ringing in the corridors of power about the missing girls in the demographic picture do not find an echo in the dusty by-lanes of the villages of these districts.

The practice of getting rid of daughters, that is known to have existed in these regions for centuries, is such that certain social groups in both societies have started facing a deficit of brides for their sons. According to a number of women we spoke to, some men are forced to remain bachelors, while for others brides are being imported or bought by paying bride price from scheduled tribes and other groups. We have no hard evidence on the extent of this practice, but it might well turn out to be a lesson in social integration. But in spite of the deficit of women, which is becoming increasingly evident, societal norms do not yet seem to be responding to this emerging phenomenon.

The prevalent social norms and practices raise a number of questions. In this context, is the passing of a national legislation to regulate prenatal diagnostic technologies any kind of effective answer? If its blatant misuse is anything to go by, the law has proved to be largely ineffective. The issue now is: will regulatory mechanisms, even if clamped at all levels or with better implementation, prevent its misuse? Will the impounding of ultrasound machines in unregistered clinics and making the maintenance of detailed registers on their use in registered clinics help to reduce their use for detecting the sex of the foetus? We believe that what is needed is a concerted effort to address the bias against girls at the source, and every action and every group that can address this issue would contribute to improving the status of women in our society.

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NOTES

1 The stipulated conditions are such that abortions performed by trained doctors who are not registered in facilities not specifically approved for abortion services are termed illegal. According to Chhabra and Nuna, in India illegal abortions may be 8 to 11 times as high as legal abortions (Chhabra and Nuna 1993). While the intention is to provide women with safe, legal, timely abortion services, given the stringent nature of the Medical Termination of Pregnancy Act, many safe abortions may be classified as not legal. At the same time, the availability of and access to legal abortion services is so limited for a large proportion of women living in remote rural areas, that in the three decades since the passing of the Act, many abortions not only have takeen place outside the ambit of the Act but are often performed in unsafe conditions leading to post-abortion complication and also to death (Clark et al. 2002).

2 There is enough empirical evidence of son preference in India and its relation to the sex ratio of the births (see, for example, Booth et al. 1994: 1259; George and Dahiya 1998: 2191–98).

3 The international practice is to estimate the sex ratio in terms of number of males per 1,000 females. However, in India, the convention has been (following the British practice, which has recently changed in accordance with international practice) to estimate sex ratio in terms of number of females per 1,000 males. We have, in this report, followed the Indian convention, since the issue is debated within the country in terms of deficit of girls or women rather than in terms of increase in men or boys.

4 The Indian Census does not collect data on pregnancies aborted, use of sex determination tests, or sex ratios at birth, and therefore it cannot directly provide evidence that sex-selective abortions are increasing in the country and that they are responsible for the current imbalance in the sex ratios of young children.

5 We could not interview any providers in the state of Haryana for several reasons. The sensitivity among the providers about violating the law was extremely strong and the activities were carried out very clandestinely. The investigators feared that, if approached, the providers would not respond to their calls or cooperate; on the contrary, they might also influence the community to not cooperate with them.

6 Knowledge of the local languages and familiarity with the regions among the principal investigators were major considerations in the selection of the two states. Also, unlike Maharashtr-

hardly any major studies on sex-selective abortions have been undertaken in Haryana and Gujarat, although both states historically are known to have practised female infanticide.

Data on sex ratio at birth are limited since a significant proportion of births occurring at home are not registered. A detailed analysis of hospital births is warranted in view of the gravity of the situation.

[8] Chorionic biopsy is a relatively simple technique involving a cervical smear that can be done during the first trimester of pregnancy, unlike ultrasound sonography, which is generally accurate in the second trimester only.

[9] Proximity to the nearest town and transport services to the villages were important considerations in the selection in Haryana villages.

[10] Since all of the field investigators from Gujarat were recent postgraduate students from the university and unmarried, a trained medical person gave them orientation on reproductive health issues. The Haryana team, it was felt, did not need such a structured orientation. However, the supervisor discussed the issues with them in the field as and when the need arose.

[11] In Gujarat, a *sarpanch* of one of the villages insisted on reading the consent letter himself. However, without discussing the letter with the field supervisor, he surmised that all the doctors who conduct abortion in the region would be taken to task. He therefore instructed the villagers not to provide any information on abortion to the investigators. It took a lot of effort to clear this misinterpretation.

[12] However, it was possible that at the time of fieldwork, some households may have been locked due to temporary migration of the people concerned. We have omitted such households from our estimations.

[13] The responses to the activity question probably reflect both the societal norms related to women's work and duties within the household, and the differentials in the field experience of the two teams. In Gujarat, the question was likely to be probed because the field investigators had been trained to probe this question in a number of other studies undertaken on women's economic activity by the employing organisation.

[14] While the inverse relationship between education and fertility is well accepted and demonstrated in the literature, it is quite likely that illiterate women were somewhat older than the literate women, affecting the differential in fertility schedule to a certain extent.

[15] In Haryana, the sex composition of the children who were not alive at the time of the survey was not available. The investigators failed to collect or ask that question. It is difficult to assess the effect of this lack of information on the overall sex ratio of the children born to the women.

[16] The other place that we visited was a rural area that had two maternity homes, both equipped with sonography facilities and owned by doctors belonging to the upper castes. The maternity ward had no patients at the time of our visit, but outpatients apparently constituted the bulk of their practice.

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Concepts and Views Related to Abortion in a Rural Community of Pune District in Maharashtra

An Ethnographic Exploration

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INTRODUCTION

In the history of public health in India, there were two landmark events that impacted directly on women's health. The first was in 1952, when India became the first country to adopt a National Family Planning Programme; the second was in 1971 when, with the adoption of the Medical Termination of Pregnancy (MTP) Act, India became one of the first countries to legalise abortion on moderately liberal grounds. However, both failed to bring about any appreciable change in society. Amongst the various reasons postulated for the failure of the MTP Act, poor implementation is considered to the chief one (Gopalan and Shiva 2000).

But it is because of this Act that Indian women are fortunate enough to have access to legal abortion services. Many people consider the Act to be revolutionary, for it allows women to both avail abortion care due to failure of contraception and have access to abortion without the husband's consent (Bandewar 2001: 35). Yet, today, a quarter of a century later, it is estimated that the number of illegal abortions is two to five times more than the legal ones (Ganatra 1999).

ABORTION SCENARIO IN INDIA

With only about 1,000 of the 15,000 doctors trained to perform abortions practising in rural areas, safe abortion facilities are not yet within the reach of rural populations. According to 1992 statistics, India had 11 million abortion cases, of which induced abortions accounted for 6.5 million. This makes the abortion rate in India 452 per 1,000 live births (Gopalan and Shiva 2000: 256–59).

Women often resort to abortion when they have an unwanted pregnancy, either due to contraceptive failure or due to non-utilisation of contraceptive methods. Lack of access of good quality contraceptives is cited to be one of the main causes of abortion (ibid.). The other major cause is its use to limit family size or as a method of birth spacing. In several cases, abortion represents an act of desperation on the part of women, as the physical, economic and psychological stress of having an unwanted child over-rides any feelings of guilt and/or fear of complications they might experience. The husbands are often unwilling to use contraception, leaving them to suffer or cope alone (Bandewar 2001: 35).

Abortion Research in India

Until the 1980s, most abortion research was hospital-based and looked at abortion as an event to be studied. It focused on such aspects as the socio-demographic characteristics of women, the reasons for abortion, morbidity and cost of abortion care. Most studies were governed by a perspective that viewed MTP as a means that the state used to achieve its goal of population control.

A closer look at 17 studies indicates that the event most researched was pregnancy.

In the 1990s, however, research on abortion—in fact, most research on women and health—seems to have experienced a shift. The thrust and purpose, the underlying philosophy, as well as the methodologies employed, were all markedly different. A new professional rigour and researchers' attempt to understand the ground realities from the women's perspective often combined to challenge the findings of earlier research.

The shift from hospital-based studies to community-based studies represented another major change in abortion research. A review of the literature on reproductive health, especially community-based studies, during the 1990s reveals that more emphasis had begun to be placed on capturing the women's perspective. Situation analysis of abortion care facilities, understanding women's abortion needs in the larger context of reproductive health and general health care needs, the decision-making process involved, quality of abortion care, and the socio-cultural, legal and political context of abortion were the new thrust areas.

The available data demonstrate that induced abortion is very common in the developing world, despite the fact that contraceptive prevalence rates have increased dramatically in the last thirty years. Although the frequency and distribution of abortion vary, there is no country where abortions do not occur (Mundigo et al. 1999).

Many estimate that the incidence of induced abortion is increasing worldwide. The reason for this is attributed to a variety of changing trends, including a desire for smaller families, shifts from rural to urban residences and increase in non-marital sexual activity (ibid.).

Why Abortion?

Abortion is an extremely personal matter that frequently engenders the need for secrecy and discretion, particularly when the pregnancy occurs outside the institution of marriage or the woman concerned is unmarried, separated or widowed. This need is especially acute in rural areas. Since privacy is the critical factor, women tend to seek practitioners who offer speedy, one-time services without the need for follow-up. In such cases, access to abortion services away from home and the notice of curious neighbours becomes more important than the expenditure to be incurred (Gopalan and Shiva 2000; Ganatra 1999; Gupte et al. 1997: 77–87).

In keeping with the rights-based approach recommended by the International Conference on Population and Development (ICPD) in 1994, Government of India launched a target-free Reproductive and Child Health (RCH) programme in 1997. Since community-needs assessment is an integral part of RCH programme, and safe abortion one of the services it offers, it becomes imperative to assess the community's needs with regard to abortion services. Yet, existing research on abortion has failed to take into account the social, cultural, economic and political context of the communities in which abortion-seeking behaviour takes place.

In focusing on abortion-seeking women, researchers tend to forget that these women are also part of a community, and that abortion-seeking behaviour, like other health-seeking behaviours, occurs in specific cultural, social, economic and political contexts. In a patriarchal set-up, this behaviour is varied, intricate and sometimes hidden, but it is also simultaneously influenced by gender, social structure and culture. An understanding of the larger community's perspective is thus necessary if we are to obtain a holistic picture of this complex issue. We therefore decided to focus our study on understanding the community's view on abortion and abortion-related needs.

OBJECTIVES OF THE STUDY

- To understand the cultural meanings of abortion in the general community.
- To understand the problems, perceptions and existing solutions for seeking abortion in the general community.
- To understand the socio-cultural factors influencing decision-making related to abortion and abortion-related care among women.
- To determine the perceptions, practices and experience of village-level health care providers such as traditional *dais* and community health volunteers (CHVs), with regard to abortion and abortion-related care.

STUDY DESIGN AND METHODOLOGY

Locale of the Study

Covering a population of about 10,000, the study was conducted in 14 villages of Velhe taluka in Pune district of Maharashtra. Though the district itself is one of

the better-developed districts of western Maharashtra, Velhe taluka comprises a hilly and drought-prone area and is relatively underdeveloped, even though it is located just 65 km from Pune city.

Despite its proneness to drought, agriculture is the people's primary occupation, with rice and *ragi* comprising the main crops with low yield. Since there are no irrigation facilities, people can only practise rain-fed agriculture. A subsidiary occupation is the production of milk. There are no industries in the area. Youth and men migrate to the nearest cities, such as Pune and Mumbai, to earn their livelihood.

Velhe enjoys good transport facilities. State transport (ST) from Pune, Mumbai and Saswad to Velhe and back is available at hourly intervals. In addition, there are several private jeeps that ply between Velhe and the Pune–Bangalore National Highway Number 4, from where connecting state and private transport facilities are available for Pune and Satara. All transport—government and private—runs between 6 am and 7 pm.

Almost all villages have telephones, i.e. in each village there is at least one telephone available, but in most cases they are non-functional. The taluka also enjoys good educational facilities—in fact, there is a graduate college just near the study area. Almost every village has a primary school up to Class VII, but children have to travel a distance of about 5 kilometres if they want to study further. Apart from some grocery stores, there are no other shops in the villages.

The population in the area comprises mainly Marathas and Kunbis—two higher castes—along with some artisan (Balutedars) castes like potters, cobblers and carpenters. The literacy rate is low. In terms of health infrastructure, Velhe taluka has one rural hospital (RH), one primary health centre (PHC) and six sub-centres, nine private practitioners and at least one traditional *dai* in almost every village. However, there is no medical facility or chemist available at the village level. Once a month, auxilliary nurse midwives (ANMs) visit the villages to conduct the immunisation programme.

Study Design

Qualitative data were collected through interviews with key informants, focus group discussions (FGDs) and in-depth interviews. Interviews with key informants were used to identify concepts (community's views and perceptions relating to abortion), and FGDs and in-depth interviews to clarify contradictions if any. 'Vignettes' were also used as a tool to collect data from the community.

Unstructured interviews were conducted with 50 key informants (25 males and 25 females) to explore various abortion-related concepts prevailing in the community. These informants were chosen from among opinion leaders, *gram panchayat* (village assembly) members, and *mahila mandal* (women's groups) presidents.

Eight FGDs (four each with women and men of the 14 study villages) spread over different age groups were conducted at Velhe, the central village in the study area. Each FGD comprised about 8–10 participants. There was one FGD each with adolescent (16–19 years) boys and girls, most of whom were students. In the young adult (20–35 years and 36–50 years) male groups, the majority were farmers. In the young adult female group, almost all were married with at least two children. Women in the middle-aged group were all housewives who also did agricultural work in their own fields. The two groups for the elderly (51+ years) had 7 male and 13 female participants respectively. The older people believed that abortion is a consequence of deviant behaviour, and very firmly declared that such things did not happen in their villages. People in the younger age groups, however, readily admitted that abortions do take place in their village.

Informal, in-depth interviews were conducted with 40 community members (20 males and 20 females) purposively selected from six villages. The sample was chosen on the basis of caste in order to understand the caste dynamics of the issue. All respondents were over 25 years old and engaged in farming. These interviews were carried out to help us flesh out the identified concepts.

PRESENTING VIGNETTES

Vignettes are imaginary situations/scenarios narrated to respondents to stimulate thought and to elicit their views on particular social problems. We used this method to help our respondents think objectively about the issue of abortion in the study area and give us their views. A total of five vignettes were presented to the respondents. These were as follows.

Vignettes for Ever-Married Women

- Married woman who currently has one son and two daughters becomes pregnant for the fourth time and does not want to bear a child.

- Married woman who has four daughters becomes pregnant for the fifth time.
- A young widow of 23 years becomes pregnant in a village similar to that of the respondents.
- A young woman of 25 years who has been separated from her husband (i.e. not living with husband) for the last two years, becomes pregnant in a village similar to that of the respondents.

Vignette for Pregnancy Outside Marriage

- A 16-year-old unmarried adolescent girl becomes pregnant in a village similar to that of the respondents.

After presenting the vignette, we asked the respondents questions about the physical, social, financial and psychological problems that the woman was likely to undergo. They were also asked to explain what, according to them, could be the reasons/causes for her condition and what sort of help-seeking behaviour would she adopt given her circumstances.

DESIGN OF FIELDWORK

Since abortion is a sensitive issue, the researchers had anticipated that the community might be hostile or object to answering our questions, particularly the elderly members of the community. They had therefore taken appropriate pre-emptive measures before starting on the fieldwork.

Our study team comprised two female and one male researchers, with the former interviewing the women and the latter the male respondents. With a background in health sciences, social work and anthropology, the team was multidisciplinary. The researchers were given further intensive training in qualitative data collection techniques, deciphering interviews, data management, data analysis and preliminary report writing.

DATA COLLECTION

Preparation of Research Tools and Pre-testing

Based on the requirements of the study, interview guides were prepared, pre-tested and finalised in consultation with experts. The guides were then translated into Marathi. Interviews with key informants were conducted in all 14 villages with the help of the village health guide (VHG). The respondents' availability and choice of venue for the interview were given prime consideration. These interviews helped the researchers in establishing a good rapport with the community.

Preliminary analysis of the data emerging from these interviews helped us to make appropriate changes in and sharpen our guidelines for both the FGDs as well as the in-depth interviews.

Strategy to Reach the Community

For the last year and a half, the Maharashtra Association of Anthropological Sciences (MAAS) has been implementing information, education and communication (IEC) activities aimed at increasing awareness about the RCH programme in Velhe. In the process, MAAS has managed to build up a good rapport with the community. This proved to be of great help in our own efforts to win the trust of the community and made it easier to collect good-quality data from them.

Visiting the villages in the evenings when people had some free time, consulting them about the data collection process and seeking their consent for undertaking the study also helped us establish a rapport with them. During the phase of data collection, researchers stayed in the villages. In turn, the community shared their problems and views with the research staff. All in all, it was something of an ethnographic experience.

Data Management

We took written notes of the responses given by key informants in their interviews. However, we decided it would be better to tape-record the FGDs and in-depth interviews. The elaboration of notes taken during key informant interviews was done immediately after returning from the field. Other data were first transcribed, translated and then analysed with the help of the computer-aided qualitative data management package, Atlas-ti. On average, it took us about 1.5 days to transcribe one interview and another 1.5 days to translate it, following which we spent another day entering the data into the computer.

Methodological and Ethical Concerns

Given the sensitive nature of the issue, it was not possible for researchers to approach the topic head-on. It was therefore decided to begin the interviews with a discussion on general health problems and then gradually steer the respondents into talking about abortion. Since our study is based on the community's perspective, we did not include the actual experiences of abortion seekers in our data.

For each interview, we sought the oral consent of respondents after explaining what our project was about and why it was necessary in the larger context, and assuring them of confidentiality and anonymity. When the interviews/discussions/vignette presentations were being transcribed, care was taken to replace original names with dummy ones. Explaining the project and its purpose was especially necessary to obtain the consent of the village elderly, who were initially hesitant to talk about a deeply personal issue like abortion. Similarly with adolescents: only those who were willing to speak were considered for participation in FGDs.

Profile of Respondents

As we have mentioned earlier, more that three-fourths (85 per cent) of the population in Velhe taluka comprise Marathas and Kunbis. Their large presence and upper-caste status enables them to wield a lot of influence on the other castes who live there. In the older age group about half of the participants were widows and widowers. The mean age of key informants and in-depth male and female respondents was 49 and 42 years. Males had more years of schooling (six years) compared to females (three years). The respondents belonged to almost all castes in the area.

CULTURAL MEANING OF ABORTION

Although with the passage of the Medical Termination of Pregnancy (MTP) Act in 1972 abortion was legalised in India, morbidity and mortality due to unsafe abortions continue to pose a major public health challenge. All communities have their own ways of dealing with the processes of birth, growth, development, maturity, decline and death, with due regard for differences in age and sex (Herskovits 1956: 52). An occurrence such as abortion, particularly if it is outside marriage, can threaten the structured relationships between individual, family and community. To address the challenge of unsafe abortions, it is therefore necessary to understand the cultural context of the community in which the abortion-seeking behaviour takes place. The community's concept about fertility, foetus, *jeeva*, miscarriage and induced abortion are presented below.

Fertility

Getting pregnant is regarded as a very important event for the woman in the study community. Since her main function is to provide the family with an heir, pregnancy not only elevates her own status in society, but also, if she successfully delivers a son, that of her family. According to our study respondents, Indian women are expected to become pregnant within one or two years of marriage.

There was some variation in community perceptions about which days are considered to be the most fertile for conception. About half the respondents said that the fourth and fifth days after menstruation are most conducive for pregnancy. In this two-day period, not only is the uterus totally clean, its opening also becomes wider, making it easier for the sperm to enter. In addition, there are some months, like July and August, and days during festivals like *Holi* (festival of colours) and village festivals that are more fertile than others. For generations the community has believed that these holy months and days come with god's blessings, and are therefore auspicious periods in which to conceive a child.

***Garbha* (Foetus)**

The community did not differentiate between embryo and foetus but referred to both as *garbha* or *potatale bal* (child in the womb). Some respondents mentioned that up to the third month of pregnancy the *garbha* is usually called *masacha gola* or ball of flesh; thereafter, until the time of delivery, it is known as *potatale bal* because it is only in or after the fourth month of pregnancy that life starts in the *garbha*. However, instead of differentiating between *masacha gola* and *potatale bal*, the community prefers to refer to a pregnant woman as *potushi aahe* (she is with child).

***Jeeva* (Life Initiation in Embryo/Foetus)**

Jeeva means life. The community believes that life in the female foetus starts early (in the third month of pregnancy), compared to the male foetus, which only begins life in the fifth month. The belief that females become active soon after conception was confirmed by our female respondents, who reported that they had experienced movement of the foetus at approximately two-and-a-half months of pregnancy in the case of female children, whereas it began in the fifth month when the child was male. The foetus is considered to be alive only when it begins to move.

Miscarriage/Spontaneous Abortion

Indians generally view women as wives, mothers and homemakers in their husband's family (Datta 2002: 1).

Every woman is therefore expected to perform her 'role of womanhood' by giving birth to a child. When asked about spontaneous abortion, most respondents described it as an 'unfortunate incident'. For a woman, miscarriage is synonymous with bad luck and family members are quick to accuse her of having caused it by eating forbidden food. The respondents stated that the major reasons for miscarriage are a small uterus or one with a wide mouth, the age of the mother (if she is very young), eating 'hot' (heat-producing) or not enough food, and lifting heavy loads. The local word for spontaneous abortion/miscarriage is '*duvatane*'.

The community was very clear about what comprises 'hot' food. If a pregnant woman consumes papaya, jackfruit, *kharvas* (first milk of cow or buffalo), bananas and groundnuts in large quantities, it leads to miscarriage. All the respondents said that no woman who wants a child would ever risk consuming such foods: '*Why to test poison*?'

Older women recalled that when they were pregnant, they did all the work that normal women did. Now pregnant women are asked to take rest from the second month of pregnancy and, despite that, they face many complications. Not many women miscarry: usually, only one among ten pregnant women has a miscarriage. Nevertheless, all pregnant women are advised to take rest!

Women who undergo miscarriage or abortion are considered by the community to be ritually polluted and are expected to observe certain rites that are associated with it. This is particularly the case with some castes or in families where 'god' resides (i.e. some member(s) of the family are said to be possessed by a god/goddess and considered as godmen or godwomen). These rites can extend from 12 to 15 days, during which period the woman is not allowed to enter the kitchen or the room in the house that is set aside for worship. However, the period for observing ritual pollution can vary, depending on the caste. And in families where there are no other women to do the day-to-day chores, this period has been conveniently shortened to four or five days. Of course, the main advantage of this ritual is that it offers women some respite from housework.

Bleeding after miscarriage is considered normal. Usually, no medical help is sought for miscarriage unless the bleeding is heavy or excessive, i.e. if the woman needs to change her menstrual cloth/pads more than five times in a day. Normally, women change their menstrual cloth only twice a day. Respondents said that the incidence of medical intervention after miscarriage is rare. Medical aid is available at the taluka headquarters (sub-district headquarters), but due to lack of good transport and other infrastructure facilities, it is difficult to get medical help at night or during the monsoons.

Abortion (Induced)

Many communities in India give great importance to women's ability to produce live children, and have their own rituals and precautionary measures to help women conceive and carry them through to a safe delivery. In the community covered by our study, children are viewed as 'god's gift': god gives a couple children because they have done something good in their past life. All the respondents said that it is all right if a couple does not want another child. But an abortion is not a preferred option because of its association with 'sin'. If couples do not wish to have child, they have several contraceptive options available to them, such as tubectomy, oral pills or abstinence.

Unsafe/Safe Abortion

According to our respondents, abortion is *always* unsafe. There is no concept of safe abortion in the community, which believes that abortion makes a woman weak and undermines her physical health. However, under certain conditions, abortion is permitted if performed before the pregnancy reaches a certain stage—i.e. up to the fourth or fifth month. Curiously, this coincides with the period that is legally permitted under the MTP Act.

Although abortion is not socially accepted, given the immense pressure that families are under to provide daughters with a dowry, the community does make allowances if a woman has only or more girls. This is one reason why families prefer sons: not only do they propagate the family, they are also the ones who will take care of the parents in their old age.

All respondents said that women with '*izzat*', i.e. prestige or respect, do not opt for abortion, but of course there are always a few exceptions. The respondents unanimously believed that a woman should follow community norms and restrict her behaviour to the prescribed socio-cultural boundaries (*maryada*); otherwise she will have to pay a bitter price. To illustrate this, one of the respondents said:

> If you feel like eating at four places, it is better to control yourself and eat at one place. Today, you might have an expensive sari to wear but tomorrow you may have nothing to wear. Instead of that, it is better to have a simple but your own sari.

Most women in the study villages want to get pregnant within a year of marriage. Postponing pregnancy might lead to not being able to bear a child later, which for them is a shameful prospect. They could also be accused of infertility. A curious finding was that, despite being aware of temporary contraceptive methods, the villagers are not willing to use them due to misconceptions such as the Copper-T affects the heart and pills lead to infertility. They prefer permanent methods; among them, tubectomy is the most widely accepted one for women. After having the desired number of children, women usually get their tubes tied. However, several wedded and unwed women become pregnant despite knowing about contraception, and are forced to seek abortion.

***Izzat/Aabru* (Respect)**

Culture provides the basis for the social, political and economic organisation of any society. It comprises a set of guidelines—both explicit and implicit—which tell the individual how to perceive, think, feel and act as a male/female member of that society (Helman 1990: 131, 153). Any deviation from these guidelines is considered a threat to the regularity of that society.

We found that *izzat* is given prime importance in the study villages. As in rural Greece, in these villages too the role of men is to protect the family honour, whereas women have to exercise considerable self-control to ensure that their behaviour, both in private and in public, is in keeping with the prevailing social norms. Women are respected in the community only if they show strict adherence to these norms, since their 'honour' is closely linked with that of their family and community. Family honour and social worth are particularly important and are constantly under the scrutiny of other families (ibid.). The community strongly believes that while a woman should protect the family's honour and social worth by behaving according to the community's social norms (*maryada*), a man should use his authority in the family to do this. For instance, if a woman, or any other person in the family, deviates from these norms, the man should use his position as head of the household to correct the transgression, either by punishing or banishing the person concerned from the family.

In earlier times, villages were compact and self-reliant. Most social, political and economic interactions took place within the confines of the village, and villagers shared a strong sense of belonging—a 'we' feeling—and collective honour. All deviant behaviour was considered a threat to the family's as well as the village *izzat* (in those days, individual *izzat* was given comparatively little importance). Older and experienced villagers (mostly men) would get together and decide on the severity of the deviance and punish the transgressor accordingly. But with exposure to the outside world, the 'we' feeling is becoming diluted and the individual is becoming more important. Our data show that villagers no longer openly question behaviour that falls outside the norm because there may be a lurking fear that they could face similar situations.

However, vestiges of the 'we' feeling can still be observed in interior villages. Of the 14 study villages, six are in the interior while eight are by the roadside. Since out-of-wedlock pregnancies are considered unacceptable, women have to either undergo a secret abortion or risk being cast out of the village forever. Sometimes, a woman might also commit suicide or, worse, be murdered. The male partner involved usually goes scot-free, for often his wrongdoings, and at times even identity, remain hidden. During interviews, respondents from interior villages strongly denied the existence of out-of-wedlock pregnancies and subsequent abortions: '*Such cases have never occurred in our village.*' In the roadside villages, though such pregnancies and abortion are condemned as 'bad', they are considered to be issues more of individual or family rather than village *izzat*.

To sum up, though all abortions are generally regarded as a sin (*paap*), the community does seem to view abortions among married women with sympathy. All respondents stated that no married woman would opt for an abortion without compelling reasons, as for example, if she has only female children or if the pregnancy poses a threat to her life. Pregnancies out of wedlock are not acceptable because in our study community (and culture) sex is permitted only after marriage and within wedlock.

Men are expected to actively defend their own and their family's honour, while women's duty lies in preserving their purity and chastity (Helman 1990: 131, 153). All respondents held family *izzat* to be of utmost

importance. Since abortion may pose a threat to this, the villagers are willing to do anything to preserve this *izzat*.

COMMUNITY VIEWPOINTS AND DECISION-MAKING DYNAMICS RELATING TO ABORTION

Though abortions in India are culturally not acceptable, over six million abortions take place in the country each year. To understand how/why this happens, we first need to understand that communities do not think in isolation; their thinking always depends on observation and experience. This is true in the case of abortion as well. In this section we look at the reasons for the disparity between the cultural understanding of abortion within marriage and outside wedlock, and the reality on the ground. The dynamics of decision-making at the family level play a critical role in arriving at an understanding of abortion at the community level. In order to comprehend the community's viewpoint on abortion, and understand the possibilities suggested by it in cases of undesired pregnancies, we have done a vignette-wise analysis, providing a separate abortion-seeking process tree for each vignette (see Appendix). After interviewing key informants to identify the concepts to be used, five vignettes were presented to every respondent. Only responses that were willingly given are reported here. Some respondents did not respond to some vignettes, while others came up with various scenarios of what might happen in each case. Therefore, the denominator varies in each tree. While identifying the concepts of abortion during key informant interviews, we discovered that the community supports abortion only in the case of women who have more or only female children. Hence the vignette of the woman with four daughters was also presented to the respondents of in-depth interviews (40), to obtain more detailed information/data about the identified concepts.

As has been mentioned earlier, our data show that, according to the community, abortion is a sin. And for each and every sin there is a punishment. Indian culture as understood in the community does not accept abortion, as it is considered '*bhruna hatya*' (killing of a foetus), and the community strongly believes that a married woman should not undergo abortion. At the same time, it finds abortion by a woman who has several female children socially acceptable. It does not condone pregnancies outside wedlock; only women who are married and living with their husbands can become pregnant.

Vignette 1: Appendix Tree 1

A married woman who already has one son and two daughters becomes pregnant for the fourth time and does not want to bear the child

In a case like this, the community felt there are less chances of a woman undergoing abortion (74 out of 86 respondents). Though the woman may want an abortion, her family members might refuse the permission. And without their permission, she cannot go for an abortion. But if she does have an abortion, the woman does not have to hide anything because she has the permission of her husband and other family members.

According to several respondents (50), there were many valid reasons for women to undergo abortion—poor economic condition, bad health and more or only female children. However, in such a situation, the majority of married women (74 out of 86) in the community would not opt for abortion. They would wait in the hope that the child would be another son. Family members, especially the in-laws (77 out of 86), would not allow them to undergo abortion. And if the woman is living in a joint family, she cannot ignore what the in-laws say. Seventy respondents said abortion is a sin of child murder, and that the onus for it is more on the woman than the husband.

In these types of cases, there is no question of individual or family *izzat*; the decision to abort is purely a family matter.

Vignette 2: Appendix Tree 2

A married woman with four daughters becomes pregnant for the fifth time

This vignette was presented only to the respondents of our in-depth interviews. Out of 40, only 32 respondents responded. All 32 said that a woman with four daughters would only think of getting a male child as a result of the fifth pregnancy. Her family members would also have the same expectation. A woman is always blamed if she is not able to deliver an heir for the family.

It was clear that the community had no objections to abortion in such a case. Female children really are an economic drain on the family, particularly after 'maturity'. Dowry, marriage and paying constant 'respect' to the daughters' in-laws place an immense cultural and social burden on parents. Twenty-nine of the 32 res-

pondents said that in these circumstances, abortion is not a sin. Eleven said that if the woman continues with the pregnancy and the outcome is again a female child, there would be further blame heaped on her. All 32 respondents claimed that the community would be supportive of such women if they decide to have a sex determination test and undergo abortion if necessary. Eighteen respondents claimed that these women prefer to go to private clinics, as both sex determination and abortion facilities are available there.

Vignette 3: Appendix Tree 3
A young widow, 23 years, becomes pregnant in a village similar to yours

In general, the community has some sympathy for a widow who has lost her husband at a young age. A young widow needs to be supported economically, socially and psychologically, and sometimes these needs put her in a situation where she can be sexually exploited. But if such a situation occurs with her active consent—she may, for instance, form a relationship with a man due to economic pressures—she is stigmatised by the community.

All 74 respondents said that the widow would be blamed if she became pregnant. Her partner would not be held responsible at all (64 out of 74). This is mainly because of the secondary status that is accorded to women in patriarchal societies.

However, 33 respondents said that such a woman could spoil other women in the village. The villagers would therefore boycott her or minimise their social dealings with her. In such cases, the honour of the village (*gavachi izzat*) is more important than that of the woman. Though the community is firmly against abortion, 64 respondents said that they could see that the woman would have no other alternative than to have a secret abortion. But very few (5) respondents suggested remarriage as a solution.

The entire family would be upset if a widow's pregnancy became public knowledge. The natal family may offer some moral and emotional support, but her in-laws would reject her, even if the person who has sexually exploited her belongs to the husband's family. Twenty-five respondents said that it is likely that family members would ask her to leave the house, while the rest of the community would condemn her for not controlling her sexuality after her husband's death. Dominant community members belonging to the '96-clan Maratha caste' mentioned that in such cases women should commit suicide to save the family as well as village *izzat*.

Vignette 4: Appendix Tree 4
A young woman of 25 years who separated from her husband two years ago, becomes pregnant in a village similar to yours

Our data show that the community does not condone pregnancy in a separated woman. Fifty-seven out of 84 respondents blamed the woman, saying that despite having a husband she chose to have a relationship with another man. According to 57 respondents, such women need to be severely castigated.

Separated women find it difficult to get support from either their natal or husband's families. According to 15 respondents, the immediate reaction of the family and community would be that she should commit suicide. Therefore, the woman has no other option but to abort the child. And by doing so, she commits a mortal sin. Seventeen respondents said that they would not want her to stay on in the village. The respondents also said that while such women are accused, the man who is responsible for her pregnancy does not face any criticism from the community.

Vignette 5: Appendix Tree 5
A 16-year-old unmarried, adolescent girl becomes pregnant in a village similar to yours

There was some difference of opinion about the guilt and innocence of the girl. Some respondents thought that someone had exploited her and made her pregnant. Others felt that she must have consented to have sex with the man; if she hadn't, why had she not screamed for help when he was forcing her to have sex? What she had done was a sin and must be punished. The community does this by considering her unfit for marriage. However, most respondents (64 out of 77) did say that now that she has made the mistake, which led to pregnancy, she has no other alternative but abortion unless, as 15 respondents pointed out, the man who is responsible for her pregnancy is of the same or higher caste and accepts her as his wife.

These responses hold several implications for the issue of pregnancy and abortion among unmarried girls. Even when the boy is ready to accept the girl as his wife, the caste dynamics (26 out of 77) of the village might not allow it. If the boy is of a lower caste, it will not be acceptable to the girl's family and other caste members

if the news about the pregnancy leaks out. As 53 respondents explained, the girl's parents or family members would prefer to keep the pregnancy under the wraps and send the girl to a distant place for abortion. If the girl's pregnancy becomes public knowledge, the fear is that they will not be able to arrange a suitable marriage for her because the prospective groom's relatives would be sure to make enquiries about her character and the family's status in the village. The family would definitely think about the loss of their *izzat*, which, once damaged, cannot be recovered. Thirty-four respondents pointed out that the community is very severe in its condemnation of a family whose daughter's misdeed threatens the village *izzat*.

Thus we can see that though abortion is regarded as a sin, the severity of the sin depends on the marital status of the woman. For instance, it is much reduced in the case of a married woman who already has four daughters and decides to abort the fifth. Further, everyone who commits this 'sin' is punished in some way, though, again, the level of punishment varies depending on the severity of the sin.

Post-Abortion Complications

In our study area, there are no post-abortion care facilities available at the village level. Our respondents did not report any incidence of severe morbidity due to abortion in the study area.

Respondents stated that psychological problems were more common. After abortion, women constantly think about the sin or '*bhruna hatya*' that they have committed. However, the burden on women who conceive out of wedlock is far heavier, as they can't even talk about their feelings with anyone. They are thus unable to express their emotions or mental anguish. The community views these problems as punishments that women have to suffer in this lifetime for the sin they have committed by aborting a foetus.

Knowledge of MTP Act

Our data show that the respondents do not know anything about the MTP Act or its provisions. Their knowledge about the facilities available for abortion is also very poor. This is true even of village-level health functionaries. As a consequence, government facilities are very poorly utilised.

About half the respondents said that they knew of some surgery called curettage that is used in abortion. Their knowledge did not extend beyond this.

Abortion and Post-Abortion Care

The general view in the community is that there is no real need for abortion services at the village level. Even if they were available, women conceiving out of wedlock would not be able to use them. Regarding post-abortion care, respondents felt that instead of just abortion facilities, integrated services should be provided in the villages. This would be more useful because in emergencies, it is very difficult to transfer the case to some other facility outside the village. The need for easy access to basic health services was strongly emphasised.

Decision-making Process

The following indicators were used to analyse decision-making relating to abortion from the community's point of view:

- Disclosure of pregnancy
- Decision of abortion
- Seeking information about abortion facility
- Abortion facility
- Accompanying person
- Decision about expenses.

Disclosure of pregnancy

About two-thirds of the respondents said that if a married woman with one son and two daughters became pregnant, she would inform her husband of the fact. The same would be true for a married woman with four daughters. It is customary in the villages for menstruating women to observe menstrual pollution, i.e. they have to sit outside the house for four days. Family members, particularly the mother-in-law, keep a close watch on the daughter-in-law's menstrual cycle. If, in some month, they see that the daughter-in-law has failed to observe this custom, the mother-in-law automatically knows that she has missed her periods. However, as the respondents pointed out, in cases where pregnancy occurs outside wedlock, the woman will try to hide her pregnancy by pretending that she is still having her periods and will therefore continue with the ritual. According to nine out of 77 respondents, an unwed girl will also do this (see Tree 5), but only for two or three months. Subsequently, as 18 respondents said, she would either tell her mother about the pregnancy herself, or her mother would know about it through her changed behaviour (Tree 5).

Almost all the respondents said that experienced women can tell if a woman is pregnant through certain signs women in this condition display, such as dry, glowing skin, increase in breast size and a distended stomach.

A widow (64 out of 74 respondents, Tree 3) or separated (38 out of 84 respondents, Tree 4) woman will try to go in for an abortion as early as possible. This is something she decides on independently. If she is foolish, she might tell her parents that she has missed her periods. But by and large, such women keep their pregnancy and abortion a secret. The community looks down on women who engage in forbidden sexual relationships. No man, according to them, would dare to even look at a woman who behaves within '*maryada*', i.e. as per the cultural norms.

Widows and separated women might disclose their pregnancy to the man who is responsible for it. Or, if they do not have the courage to take the decision to abort on their own, they might disclose their pregnancy to their mother, sister or some other person close to them.

Decision to abort

If married women with two daughters and one son become pregnant, their family members usually ask them to continue with the pregnancy and get a tubectomy done after delivery (70 out of 86 respondents, Tree 1). Such women carry on the pregnancy unless there is some major problem like lack of money or risk to the mother's health. Since the majority of families in the villages are still joint families, the daughter-in-law's first duty is obey the family elders. In these families, the mother-in-law in consultation with her son usually takes the decision for abortion. In nuclear families, the final decision-maker is the husband. The respondents mentioned that although all males of the family are involved in the decision-making process, the final say lies with the mother-in-law and/or husband.

When a married woman with only daughters becomes pregnant, the family usually advises her to go for sonography. She is happy to do this because, according to the Hindu religion, every man should have at least one son (Dawis 1981: 419, 421). If the foetus is determined to be female, she is advised to undergo abortion. All respondents (32, Tree 2) said that these days, when the price levels are so high, it is not possible to raise so many daughters and get them married. Among the Hindus, marriage is regarded as compulsory (ibid.). In the study area, the amount spent on a daughter's marriage ranges from Rs 100,000 to Rs 150,000 (US$ 2000–3000). It is impossible for a father to earn and save Rs 500,000 (US$ 10,000) only for getting his daughters married. But here, too, it is the mother-in-law and the husband who take the final decision.

While very few respondents said that there is no difference between sons and daughters, they did say that, instead of waiting for a son, it is better to get a tubectomy done after two or three children. According to them, a family needs both daughters and sons. When parents die, a son is needed to perform the death ceremonies that will assure their salvation, and a daughter is needed to mourn the death (weep and cry). There is belief in the community that without a daughter's wailing and weeping, heaven does not 'open' its doors.

Thus, as has been pointed out earlier, the community takes a practical view of abortion in instances where the woman has only daughters (all 32 respondents, Tree 2): '*If a son is not in her fate, then there is no need to give birth to more girls*'.

The respondents listed out certain alternatives and steps that women who conceive out of wedlock (including separated women) follow when they decide to abort. As five out of 84 respondents pointed out, she first is to try to hide her pregnancy by pretending that she is having regular periods. In the meanwhile, she also tries various options like eating papaya, *kharvas* and other 'hot' foods. In this context, the overwhelming view was that no matter what the woman eats, she would not succeed in her effort to abort. Her pregnancy is bound to be exposed because it is the result of a wrong deed. When she fails in her efforts, she will inform her sexual partner who, if he is supportive, will take to her to the clinic. However, most respondents felt that in such cases, the partner very rarely supports the woman. Men just use women for fun.

If a widow living with her in-laws becomes pregnant, she will be packed off to her natal home and the in-laws will break off all relations with her. If she is living with her parents, almost all the respondents said that after abusing her, the parents would kick her out, saying that she is 'dead to them'. Such pregnancies pose a threat to the family '*izzat*', preserving which is of prime importance in the community. However, adapting to the times, the villagers have become a bit liberal these days.

Instead of throwing her out, the widow's family may well take her for an abortion secretly.

Respondents reported that usually, separated women take the decision to abort on their own. This is rarely the case with widows and unmarried women, unless they have money of their own.

Seeking information about abortion facilities

When asked how people know where to go for abortion, the spontaneous response was that now everybody has become very clever, no one is ignorant. The main source of information about abortion facilities is advertisements in newspapers and magazines, and on state transport buses. People in the study area also have close contact with Pune city, which they visit frequently. It is therefore not difficult for them to find out about the facilities available there. Also, in every village there are a few people—an ANM, a literate woman, an *anganwadi* worker, the village health guide, a *dai*, a multipurpose health worker (MPW), or even the village gossip (*gav mavashi*)—who know of several facilities. They become a major source of information for the villagers.

Unless the person is very close to them, no one will directly seek such information from anyone. Most respondents said that this information is usually sought under the pretext that someone else needs it. Women gather this information from other women when walking to the river to wash clothes, while working in the fields, or while fetching water. Men get such information during gossip sessions with friends.

All respondents stated that information about abortion facilities includes the name of the clinic and the time and money required for the procedure.

Choice of provider

The choice of provider is an important indicator of the decision-making process for abortion. Apparently, about 20–25 years ago, abortions were carried out in the village itself, but it proved to be too risky a business both for the abortion seeker and abortion provider. Now that modern medical facilities are within easy reach, there is no traditional method used for abortion in the study area. This was clearly stated by all respondents. Most were of the opinion that a married woman wanting an abortion would probably go to the government hospital. Since the abortion is her family's decision, she can do this openly. The lengthy procedures followed in government hospitals also do not pose a problem, since she does not have anything to hide and the abortion does not need to be done hurriedly. But if the woman comes from a rich family or if her family is concerned about her health, then she will only go to a private clinic. However, as pointed out by the respondents, this is a rare situation.

As we have already said earlier, widows, separated women and unwed girls prefer to use private clinics, since, because their pregnancy is socially unacceptable and abortion is considered a sin, the element of secrecy is of paramount importance. Women who conceive out of wedlock also use private facilities, but the farther away they are the better. These are clinics where fast procedures are available, minimum or no paperwork is required and no follow-up is recommended. Using some plausible pretext to explain her absence from the village, a woman can thus visit the clinic in the morning and be back home by the evening.

Expenses for abortion

Cost is an important consideration while taking a decision about abortion. Almost all the respondents stated that no family takes such a decision without thinking about expenses. Married women therefore tend to use a nearby place, such as the government hospital, where the charges are not very high. Abortion is often delayed if the family is economically constrained or if the money cannot be raised in time. However, if the woman already has several daughters, or if the pregnancy is an unsanctioned one, no thought is given to the expenses. Particularly in the latter case, the women (or their family) take loans or pawn jewellery and vessels to somehow manage the expenses, because while getting rid of the unwanted pregnancy is important, of even more importance is that this be done secretly. To maintain secrecy, they are willing to spend any amount of money.

Accompanying person

Because there is no secrecy involved, it is the mother-in-law who usually accompanies a married woman seeking abortion. However, our question about who accompanies women who are aborting an out-of-wedlock pregnancy elicited varied responses. According to the majority of the respondents, it is the parents who accompany the woman in cases of socially unsanctioned pregnancies, although they may do so under the pretext of visiting relatives. But according to some respondents, she would have to go either alone or with some close

female relative like an elder sister or aunt. The other option mentioned was the male partner responsible for the pregnancy.

Cultures are never static; influenced by other human groups around them, they are constantly in a state of flux (Jha 1994: 69). This is certainly true of our study area. Earlier, pregnancy outside marriage and abortion were strongly stigmatised and the transgressor was punished for her deviant behaviour. This punishment took the form either of being rejected by family and community, or being forced to commit suicide. With the passage of time, and especially because of the proliferation of nuclear families, the strong sense of communal belonging (or the 'we' attitude) has been diluted and replaced by a more individualistic outlook. So long as it is not done openly, even abortion of pregnancy outside marriage is accepted, albeit reluctantly. The attitude now is: '*These days, everything is permitted. It has happened to someone else today. What if tomorrow it happens in our family?*'

VILLAGE-LEVEL PROVIDERS' PERSPECTIVE

The MTP Act permits abortion under a broad range of social and medical conditions, including saving the life of the woman, preserving her physical and mental health, pregnancies resulting from rape or incest, and foetal impairment or contraceptive failure. Except in the case of medical emergency, abortions are legally allowed only within the first 20 weeks of pregnancy and must be performed by a registered physician in a government hospital or in a facility approved by the government. In contradiction to these permitted conditions, studies show that about 90 per cent of induced abortions take place at other than registered institutions. In a rural community-based study in Maharashtra, it was found that abortions take place mostly in the private sector (Ganatra 1999). To explore the community's perceptions about abortion and abortion-related care, it is therefore very necessary to take into account the perceptions of health functionaries.

The providers included in the study are basically village-level health care providers. Six *dais*, one male community health volunteer (CHV), one private practitioner (Ayurveda) and two auxiliary nurse midwives (ANMs) were interviewed as key informants.

Need for Abortion

All six *dais* held the opinion that married women, except for those who have only daughters, should not have abortions. All of them believe that abortion is a 'sin' because it is *bal hatya* or *bhruna* (foetus) *hatya*. They

Community's Understanding About Abortion

Variables	*Vignettes*				
	Married woman having one son and two daughters	Married woman having four daughters	Widow	Separated	Unwed
Blame for Pregnancy	No	Female foetus	Yes	Yes	Yes
'*Izzat*'	—	*	****	*****	****
Community's approval for abortion	Apathy	Yes Sympathy	Yes Strong stigma	Yes Strong stigma	Yes Stigma Little sympathy
Final decision-maker	Mother-in-law/ for abortion	Mother-in-law/ Husband	Self /Parents Husband	Self	Self/Parents
Providers	Govt. or private Set-up	Private and/or Govt. Set-up	Private Set-up	Private Set-up	Private Set-up
Consideration of economic affordability for abortion	Yes	?	No	No	No
Secrecy maintained	No	No	Yes	Yes	Yes
Accompanying person	Mother-in-law	Mother-in-law	Parents/Sister/ Aunt/Partner	Alone/Partner/ Friend	Parents/Aunt/ - Partner

Notes: ***** indicates maximum threat to '*Izzat*' and '—' indicates no threat;
'?' means that there is no economic consideration for sex determination, but for abortion government facilities may be used.

were very clear about the fact that they are *facilitators for childbirth*, not abortion. The *dais* further reported that about 15–20 years ago, abortions used to be conducted in the village itself. Even then they were rare. But now that medical facilities are available, there is no need for them to accumulate the 'sin' of conducting abortions. Curiously, throughout the interviews, the *dais* did not once use the word abortion (*garbhapat*). They preferred to use the local euphemisms for it, such as *var khali kele, kale dhavale karun aali* or *padun aali*. Though a bit restrained while talking about abortion, they had no hesitancy in describing the growth of the embryo in the womb. According to them, in the first two months of pregnancy the *garbha* (embryo) is just a *moose* or ball of flesh. It is only by the end of the fourth or fifth month of pregnancy that life starts in an embryo. All of them said that if abortion is the only alternative, it is better to have it by the fourth month of pregnancy.

The private practitioner and government health functionaries were more concerned with the reasons for abortion than its socio-cultural aspects. The government providers mentioned that if a married woman wants to undergo an abortion due to contraceptive failure, then she must immediately adopt some contraceptive measure after the procedure. They pointed out that in villages, daughters-in-law do not have any say in the family. It is therefore very difficult for them to adopt any family planning method. Sometimes, due to the heavy load of household work, women do not get time to go to the hospital to find out about the different available methods for family planning, and they are too shy to ask others about contraceptives. Both the private and government health care providers corroborated that there *are* a few cases of abortion outside wedlock in the villages and they all go to a nearby town for abortion. Because of the need for secrecy, such cases rarely come to them. They too felt that abortion must be carried out within the third or fourth month of pregnancy because after that the woman may experience various complications.

Reasons for Abortion

The *dais* were quick to point out that the rate of abortion in Velhe is low, with fewer women going in for abortion in this area. The major reasons for abortion, according to them, were poor economic condition of the family, many female children, threat to the health of the expectant mother and pregnancies outside wedlock.

The responses given by the private practitioner and the government health care providers reiterated the *dais*' statement. They, too, said that married women rarely undergo abortion unless the economic condition of their family is poor or if they have only female children. They also gave pregnancy outside wedlock as a major reason for abortion.

Methods of Abortion

In the days when abortions were conducted in the village, the *dais* said they would tie a *neem* stick with some string and insert it into the uterus. This was then a fairly common method for abortion. The *dais* are not aware about the modern methods used by doctors. The only method they have heard about is curettage.

The private practitioner and government health care providers also stated that dilation and curettage (D&C) is the most widely used method. They are aware of other methods, but cannot use them due to non-availability of the requisite facilities in the area, including in government hospitals.

Safety of Abortion

The *dais* stated that abortion is never safe because it is a forced procedure, like squeezing pulp from a raw mango. The private practitioner and government health care providers were more realistic. They said that abortions carried out after the fourth month would create more complications. They also cautioned that abortion seekers need to take proper care in order to avoid post-abortion complications like heavy and continuous bleeding, low backache and problems of the uterus.

Knowledge of MTP Act

Our data show that knowledge about the MTP Act among the providers is very poor. The *dais* know absolutely nothing about the Act, but they are aware that sex-selective abortions are prohibited and legally banned. When asked how they know this, they said they had watched it on 'television'.

None of the providers had any accurate information about the legal aspects of abortion, though the ANMs knew a bit more than the others. The private practitioner could not even say what methods are available for abortion. Perhaps it is just as well that these health care providers play little or no role in providing abortion services or abortion-related care in the study area.

It is clear from our data that more than those of other

health providers, the views of traditional *dais* on abortion seem to coincide with those of the community. This is not surprising, considering that *dais* are part of the community and share its cultural beliefs.

DISCUSSION AND CONCLUSION

Our study aimed at exploring abortion and abortion care-related needs in Velhe area. It is unique in the sense that it deals with the community's perceptions regarding abortion rather than the abortion seekers' experiences and views.

Cultural Meanings of Abortion in the Community

Pregnancies are recommended only after marriage. Pregnancies outside wedlock are forbidden by society. A secret abortion is the only way for social survival. In the study area, sexual relations are permitted only after marriage, and that too only with the spouse.

When a woman gives birth to a child, the father's identity is essential for social approval. Among Hindus, children are identified by their allegiance with the family line of their father (Dawis 1981: 419, 421). Due to this cultural norm, the social stigma associated with out-of-wedlock pregnancies is very strong. Blame is usually attached to the woman, who is constantly castigated for breaking community norms and seeking sexual relations outside of marriage. Since, to preserve their family *izzat*, even her family is not ready to support her, the only viable alternative available to her is to secretly terminate the pregnancy. The other alternatives are to leave the village or commit suicide. A secret abortion not only saves her family's *izzat*, it also saves her life and allows her to stay on in the same village. It is therefore a mode of social survival. If, after the abortion, someone from the village comes to know about it, it does not matter much since there is no real proof left. It is important for the woman to stay on in the same village since it is very difficult for her to uproot herself and settle down in a new place.

Fertility is Important for the Community

Fertility is a universal human concern and perpetuating the population is an important function that the family performs (Jha 1994: 69). In the study area women are expected to produce a baby within one or two years of their marriage. Community pressure to do this is so excessive that newly married couples are more than willing to prove their fertility as soon as possible in order to avoid the stigma of infertility.

Several misguided notions about contraceptives seem to be circulating in Velhe. For instance, people believe that Copper-T causes heart problems and oral pills lead to infertility. The refusal to use temporary contraceptives means that there is less spacing between children. The community feels that it is better for parents and children if they grow up together (i.e. have children as early as possible). Respondents said that it is not worthwhile for a woman to disagree with the family over the timing of childbirth, the argument being that since women *must* have children, they might as well have one immediately after marriage so that no one can accuse them of infertility. Doing this will elevate the woman's status in the family as well as ensure her acceptance within it. We can thus observe a strong impact of Hindu culture in the study area. Only women who adhere to societal norms can lead a satisfying life. Norms are necessary to save women from the inherent weakness of their nature. She therefore needs a man's protection, and to that extent is dependent on him (Prabhu 1995: 28).

Nowadays, after conception, women are paid much more attention compared to earlier times. In those days women were not very conscious of their health; but now, due to various national programmes such as RCH and Integrated Child Development Scheme (ICDS) women have become aware about their health. Family members also take a little more interest in looking after women during pregnancy. For instance, *Dohale* is used as a means to satisfy certain needs of pregnant women. It serves two functions; one, it marks the woman's transition into motherhood; two, it helps her avail the nutritional and emotional support she requires during this transition.

The community also advocates certain precautions that help in carrying women through to a safe delivery. The main one is to restrict the pregnant woman's consumption of 'hot' food. For generations, 'hot' foods have been considered harmful during pregnancy. It is believed that consuming food items like papaya, banana, *baajra* and *kharvas*—which are identified as being 'hot'—during pregnancy leads to miscarriage. Caught as they are in the transition from the traditional to the modern, younger women, though not quite subscribing to this belief, are nevertheless hesitant to risk flouting it.

Abortion is a Sin

There is a strong belief in the community that god 'gifts' a child to couples as a reward for some past good deed. To deny this gift (abortion) is tantamount to a sin. The community also equates abortion with the murder of a child, since it perceives abortion to be the voluntary and forcible removal of the foetus. It is therefore both a sin against god and a murder, transgressions that need to be punished. The severity of the punishment, however, would depend on the reason for abortion. According to Hindu culture, an ideal woman is one who displays purity and exemplary conduct in spite of hardship. If she keeps within societal norms, she will not face any problems (Herskovits 1956: 52).

Community View of Abortions Within and Outside Marriage

Married women seeking abortion

Despite believing that abortion is a punishable sin, the community does make some concessions in certain circumstances. While it is true that a child is god's gift, which should not be refused, the community sympathises with women who have a large number of daughters or only daughters. Since girls are regarded as burdens—a drain on the family's financial resources—these women are permitted to have an abortion, provided the foetus is determined to be a female. Generally, only a woman who has and is living with her husband can become pregnant. With the family's permission, such women can undergo abortion after sex determination. An earlier study conducted in Maharashtra by Ganatra (1996: 34) showed that sex-selective abortions were very common in their study area. Another study conducted by Gupte et al. (1994–96: 35) in Maharashtra reported that four-fifths of the women in their sample said that they would prefer to go to a private hospital for sex determination tests. This study also revealed that communities allow women to undergo abortion after sex determination, particularly those who have more or only female children. A community-based study done in Punjab (Nayar 2002: 39) also pointed out that the practice of female foeticide has the approval of the general public, the leaders, health workers as well as doctors. It seems that there is not much variation in how sex-selective abortions are viewed at the all-India level.

Out-of-wedlock women seeking abortion

Abortions outside wedlock, however, were viewed with disfavour. Pregnancy among widows and women separated from their husbands reflected deviance from accepted cultural norms and societal values. As discussed earlier, only pregnancies within marriage are acceptable, which is one reason why marriage is such an important institution in India. Women who do not have husbands should not express their sexual urge; even better, they should not have it. But even in this category of women, there is more sympathy for widows, since they are seen as having been cheated of their husbands by a trick of fate. However, women who have separated from their husbands and prefer to have sexual relations with some other man are a different kettle of fish. The community has a very negative attitude towards them and to avoid suffering public humiliation, the women have to resort to secret abortions.

Premarital sex is also frowned upon. Unmarried girls are expected to wait until they are married to express their sexual urges. Participating in sex before marriage can lead to undesirable consequences, such as pregnancy, which is only acceptable within a marriage. However, considering their youth and innocence, and the likelihood that some man has taken advantage of this, the community is inclined to show some sympathy towards them.

Various studies conducted in India show that a sizeable proportion of women who seek abortion are unmarried girls or women who conceive out of wedlock. In Delhi (Sood 1992: 61), 5–6 per cent of the total women who resorted to abortion were unmarried. Studies conducted in Calcutta (Iyengar 1989: 62) and rural West Bengal (Mondal 1989–90: 81) echo a similar need for abortion among unmarried women. Thus, a total of 17 per cent (Iyengar 1989) and 10 per cent (Mondal 1989–90) of abortion seekers were unmarried girls in Calcutta and rural West Bengal. In the West Bengal study, about 3 per cent of total women seeking abortion were divorcees.

These viewpoints clearly show that, in general, the community does not accept abortions. Married women having more or only female children can undergo abortion but those who are not married should not express sexual desire or indulge in deviant behaviour. However, the community has begun to recognise that as human beings, everyone needs some measure of emotional and sexual support. It is perhaps this recognition

that prompted respondents to suggest that a widow should be allowed to remarry, that a separated woman should return to her husband or divorce him and get married to the man of her choice, and that unmarried girls should get married. But in the meanwhile, she should control herself. This is in striking contrast to community expectations some years ago, when it was customary for a woman to shave her hair after her husband's death, refrain from wearing colourful clothes, bangles and jewellery, or even apply *kumkum* (red mark) on her forehead. A study conducted by Cehat (Gupte et al. 1994–96) mentions that women who had secret abortions had to have them to avoid the stigma attaching to pregnancies due to sex outside marriage. In our study too, the community holds the same view, but it also suggests ways by which to avoid such kinds of pregnancies. However, while admitting the need for abortion services, the community recommends the provision of better and more general health services in the villages, rather than just abortion services.

Socio-cultural Factors Influencing Decision-making Relating to Abortion

Data reveal that the community supports abortion in the case of a married woman who has many or only female children. A woman who produces only girls is blamed and harassed by the family. In addition, it is not economically viable for a family to bring up so many girls. Since such a woman will be aborting the foetus, not for her own sake but for her family's, she will be behaving in keeping with societal norms. Hence the severity of the 'sin' she commits will also be less.

Even in the case of the married woman who wants to abort her fourth pregnancy, the community did not approve of the decision, but also did not want to interfere in any way, since it considers this to be a family matter. According to the community, a woman who has the support of the family does not have to worry about the community's reaction. In any case, since abortions among married woman are rare, the community is able to overlook it in this case.

Since abortion among married women does not have to be hidden, expense is an important consideration in the choice of provider. In such cases the woman's family will try to find out a nearby place, which they can afford. There would be no objection to using government facilities, despite the time-consuming and lengthy procedure they follow. The mother- or sister-in-law would most likely accompany the woman. According to the community, the decision-making process for abortion is less complicated, and therefore may not cause much mental stress to the woman or her family.

Where pregnancies out of wedlock are concerned, both the decision-making process and the abortion are kept secret. Such women choose a facility that is far away and offers quick service and confidentiality. According to the community, cost considerations are not important in such cases, as the pressure to maintain secrecy is immense. Since pregnancy and abortion outside wedlock threaten the family and village *izzat*, socio-cultural factors such as honour of the village, humiliation and social survival play a major role in the decision-making process.

Though the community differentiated between the decision-making process within and outside marriage, no caste-wise differentiation was observed. Socio-cultural norms seem to prevail uniformly throughout the study area.

Perceptions, Practice and Experience of Village-level Health Providers

At the village level, health care is provided by community health volunteers (CHVs), ANMs and traditional *dais*. The providers covered by our study did not play any specific role in providing abortion services. It was observed that ANMs and CHVs are more programme-oriented and viewed abortion as merely a medical procedure. They were aware of the existence of the MTP Act, but were unable to give the rationale behind it. The *dais*, however, showed no awareness of the Act, and were clearly more influenced by the prevailing social and cultural norms. According to them, since both conducting and undergoing abortion are sinful acts, they themselves no longer conducted abortions. Since modern medical facilities are available and accessible, traditional methods of abortion are no longer followed in the study area.

Providers stated that abortions, particularly among married women, are rare and those who want to undergo abortion prefer far-off places to facilities available nearby. We found that between 1999 and 2000, not a single abortion was conducted at the primary health centre (PHC) close to the study area.

Providers reported that abortions due to pregnancies outside marriage are increasing. The community and village-level providers are against having abortion ser-

vices in the villages. They feel that such services might increase the incidence of unwanted pregnancies, including pregnancies outside marriage. Since abortions are not very frequent among married women and abortions to terminate outside-wedlock pregnancies are done in secret, those suffering from post-abortion complications do not seek the help of village-level providers.

POLICY, PROGRAMME AND RESEARCH IMPLICATIONS

Broadly speaking, the abortion policy of a country is the product of the social, political, economic and religious context in which it is embedded. More specifically, the nature of a country's abortion laws and policies depends upon their legal heritage, i.e. the legal system to which the country adheres, the interactions of that legal system with the concurrent or prior legal system, and the ways in which laws are interpreted and policy enforced.

We hope that the implications of above findings will be useful to policy planners and programme personnel as well as researchers.

The study findings reveal that there is an unmet need to make the community aware about temporary contraceptive measures to avoid abortions. Why is there a gap in the knowledge and practice of family planning methods? What is the specific knowledge regarding family planning? As the community allows sex-selection test and female foetus abortion for women who have more or only daughters, there is a need to conduct research on such couples who only have daughters to understand the economic, social, cultural, psychological burden on them, the family and the girls themselves. It is important to involve the community in the research to find out how the community may become more responsive towards improving the status of out-of-wedlock women and reduce the drudgery they currently face. As abortions were not a part of the community's day-to-day problems, they preferred having general health services at the village level and did not show any preference for specialised abortion services at the village level.

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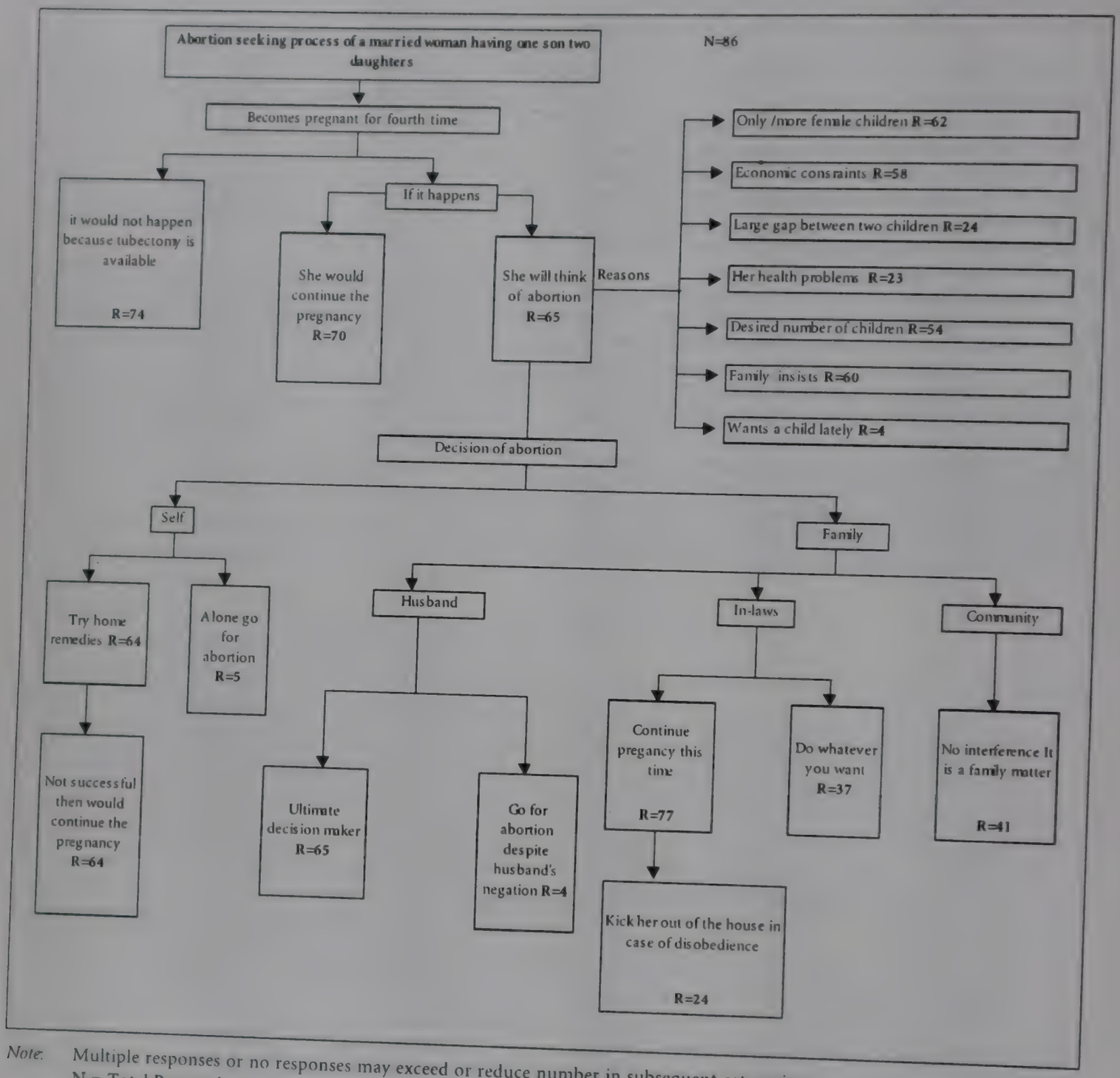
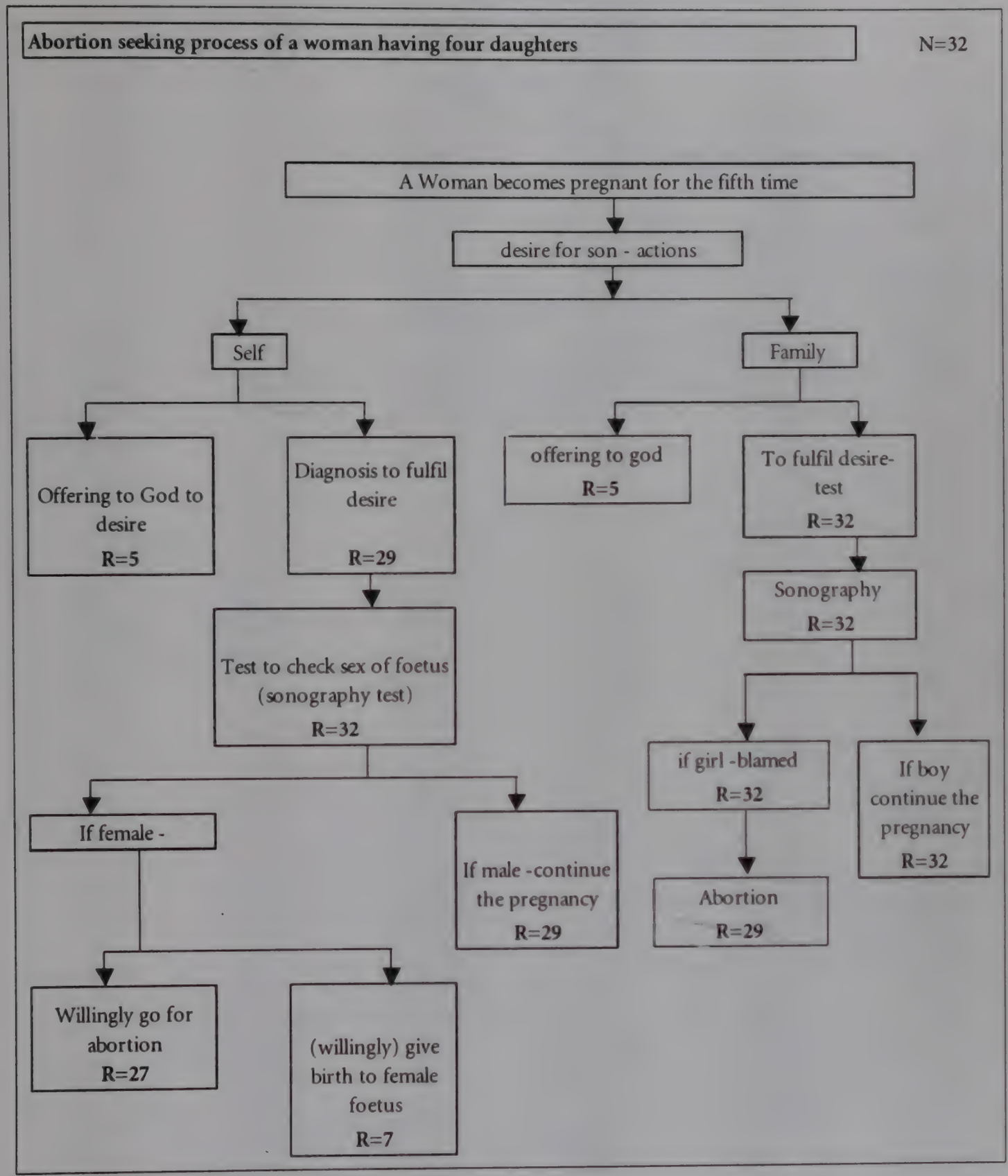
Appendix

Tree No. 1



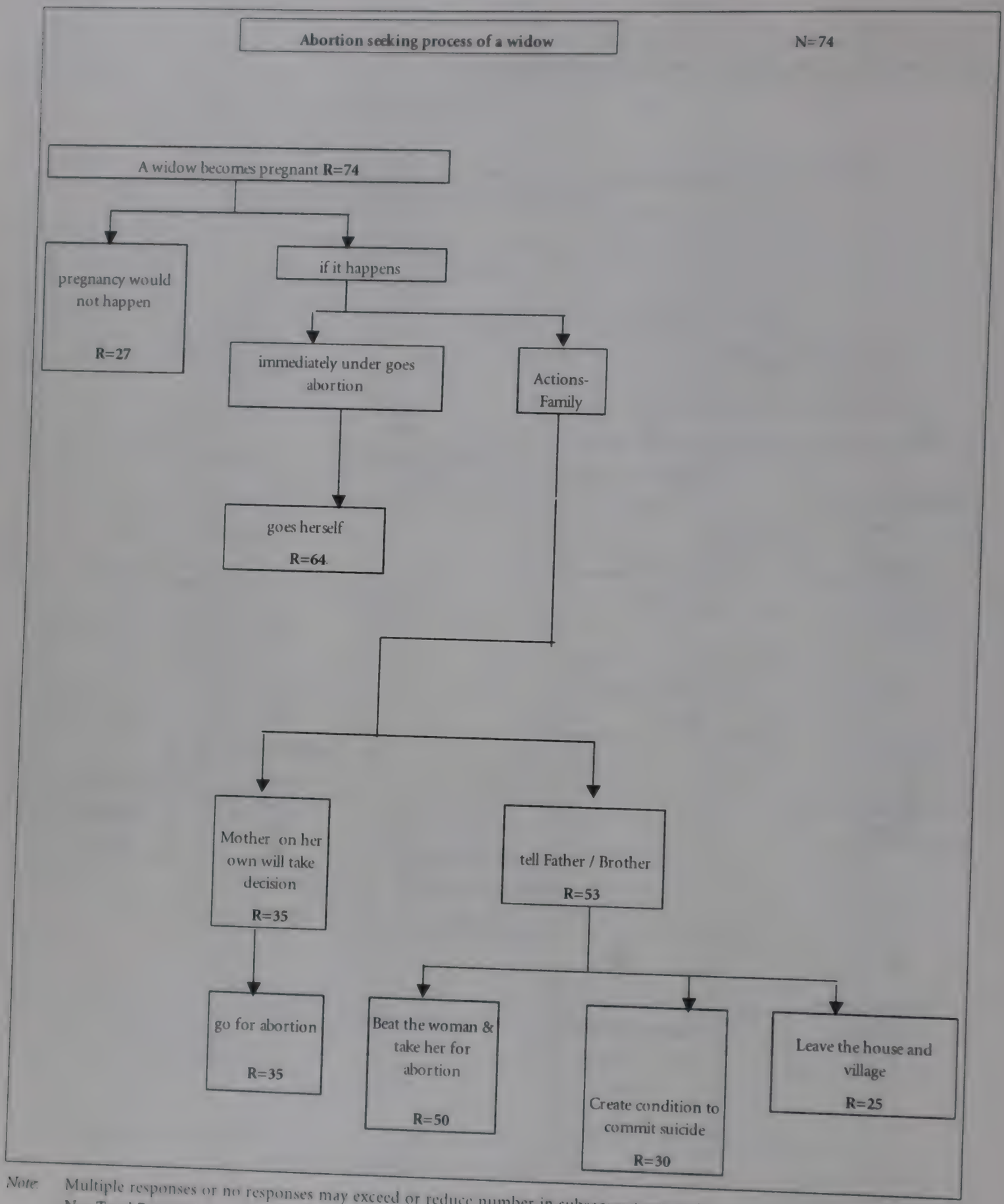
Note: Multiple responses or no responses may exceed or reduce number in subsequent categories.
N = Total Respondents
R = Number of Responses

Tree No. 2



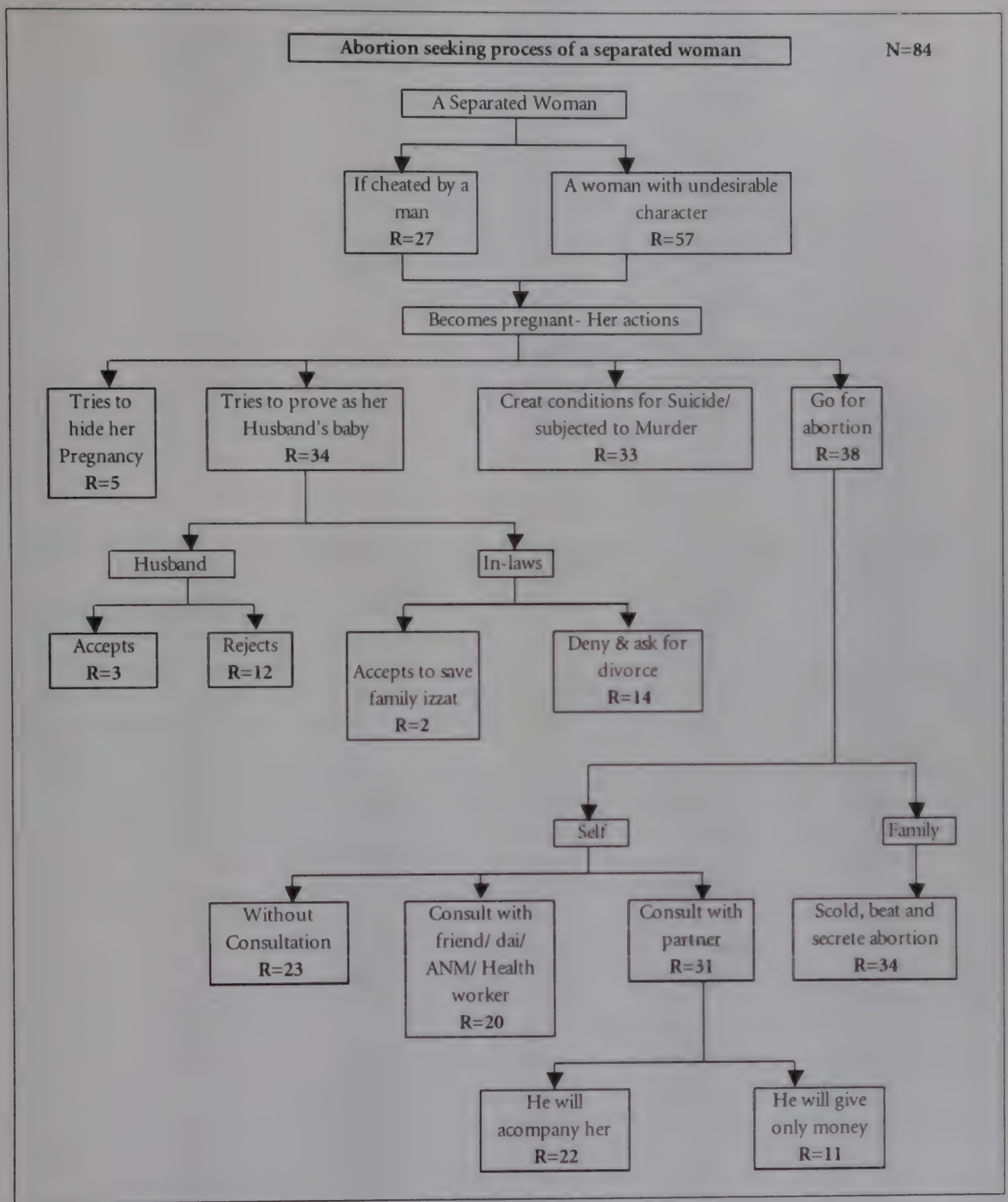
Note: Multiple responses or no responses may exceed or reduce number in subsequent categories.
N = Total Respondents
R = Number of Responses

Tree No. 3



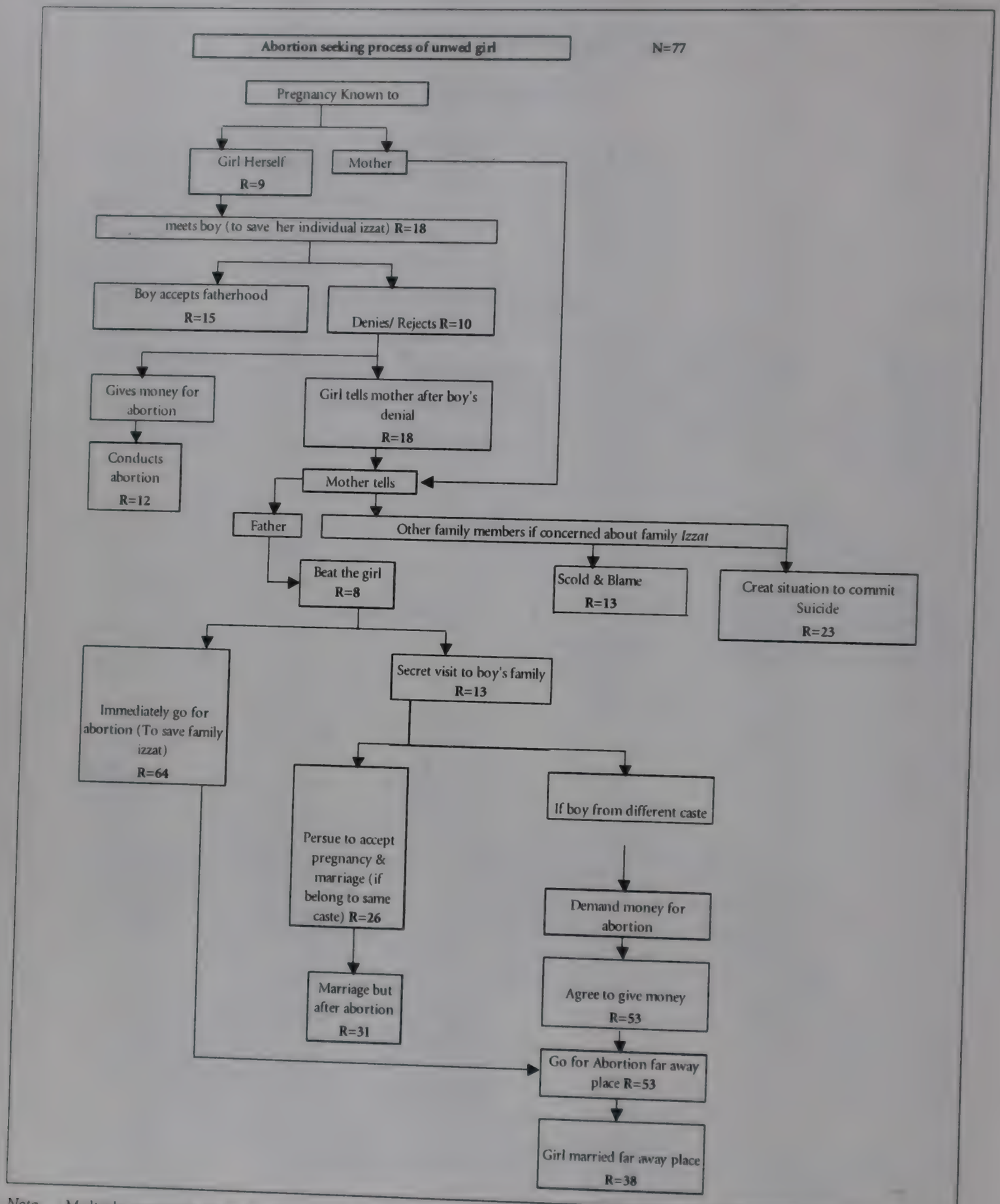
Note Multiple responses or no responses may exceed or reduce number in subsequent categories.
N = Total Respondents
R = Number of Responses

Tree No. 4



Note: Multiple responses or no responses may exceed or reduce number in subsequent categories.
N = Total Respondents
R = Number of Responses

Tree No. 5



Note: Multiple responses or no responses may exceed or reduce number in subsequent categories.
N = Total Respondents
R = Number of Responses

Post-Abortion Care through the Public Health System

M. PRAKASAMMA

INTRODUCTION

Roughly 15 per cent of annual maternal deaths that occur in India are due to unsafe abortions (Johnson 1999) and, of them, most take place because of low-quality abortion services and poor post-abortion care, leading to bleeding, infection and sepsis. Almost all these deaths are preventable.

Despite a reasonably flexible Medical Termination of Pregnancy (MTP) Act, most abortions in India are performed outside the legal and public health system, resulting in a high number of unrecorded and unsafe abortions (UN Abortion Policies 1993; ICMR 1989; Mathai 1998). It is estimated that 13 per cent of all illegal abortions worldwide occur in India (WHO 1991). Although the country saw a fivefold increase in the number of institutions offering MTP services between 1972 and 1997, the number of MTPs (1.4 per cent) performed in these facilities did not witness a proportionate rise. In addition, most of these facilities lacked functional equipment and trained manpower, or both, to provide MTP services (Chhabra and Nuna 1994: 244–47).

The principal reason for induced abortion in a marital relationship is an unwanted pregnancy. The other reasons are health problems, financial constraints and marital status (Sinha et al. 1998; Barge et al. 1997; Jeejeebhoy 1998: 1275–90). Most abortions that married women undergo are due to poor awareness and inadequate services related to contraception (Gupte et al. 1997: 77–86). The decision to undergo abortion or continue pregnancy is often made not by the woman herself but by other family members—husband, mother, mother-in-law or others. The socio-cultural and gender factors associated with abortions out of wedlock further complicate access to services due to the need for confidentiality.

The most recognised and frequently occurring complications arising from unsafe abortions in India are: pelvic infection followed by sepsis, incomplete abortion, haemorrhage, and uterine and cervical injuries (Barge et al. 1997; Kerrigan et al. 1995; Greenslade et al. 1994: 1–4; Maitra 1998). These can be tackled with the help of carefully planned post-abortion services delivered through an efficient outreach and referral system. Peripheral health services (village, sub-centre and primary health centre [PHC]) are unable to deliver post-abortion follow-up care to women who undergo abortion in their area. Poor coordination between primary and secondary health systems and poor linkages between public and private services do not facilitate such services. In fact, the abortions performed are often not even recorded.

The role of peripheral health workers (ANMs) in the provision of abortion services is generally limited to referral and follow-up of abortion cases. They are not trained to perform abortions even in early pregnancy.

In addition, because ANMs do not usually live in the villages they service, women are hesitant to seek their services for abortion. They prefer to approach illegal and unsafe providers who are easily accessible, or, if they can afford it, go to private clinics and hospitals. The potential of mid-level and peripheral service providers in abortion care thus needs to be re-examined and expanded, and the access and quality of abortion services in both the public and private sectors improved. In addition, safe and easy-to-use abortion technology needs to be piloted and promoted in outreach areas to improve access and reduce the hazards of unsafe abortions.

Our study addresses critical issues related to women and service providers in the provision of safe abortion services and post-abortion care. It deals with the perspective and problems of women who have undergone abortions in government hospitals, and assesses the coverage and quality of the post-abortion services they received. It also deals with the perceptions, practices and problems of service providers in the same area.

RESEARCH QUESTIONS

In particular, our aim was to address the following questions from the perspective of women and service providers:

- Do women receive post-abortion care and counselling from the public health service providers? What is the percentage of women who access the services of ANMs or other service providers? What is the content and quality of these services?
- What are the factors that hinder women from actively seeking the help of public health service providers during and after abortion? What do women expect from service providers in relation to abortion and post-abortion care?
- What are the economic and health consequences when women cannot access services from the public health system?
- How sensitive is the health system in general, and service providers in particular, to gender concerns such as confidentiality, decision to seek abortion, and privacy? What factors hinder the provision of post-abortion services by ANMs and other service providers? What needs to be done to improve the provision of post-abortion care and counselling?
- What are the differences in perceptions between post-natal and post-abortion care? Are women perceived and treated differently by service providers? What is the relationship between abortion, MTP and family planning acceptance?

STUDY OBJECTIVES

- To assess post-abortion follow-up services provided to women who have undergone abortion in a government hospital.
- To assess the profile, perceptions and problems of women undergoing abortions in government hospitals.
- To identify women in a selected community who had had abortion(s) within a year prior to the commencement of the research and assess the services they received from the public health system.
- To assess the perceptions, practices and problems of service providers: doctors, nurses, ANMs and others.

OPERATIONAL DEFINITIONS

For the purposes of the study we defined *post-abortion care* to include assessment and management of complications following abortion, post-abortion family planning counselling, and provision of support to the women and their families. The *post-abortion follow-up period* was defined to cover a period of six months after abortion. *Service providers* denoted all those who had a role in providing services either in the selected hospital or in the villages covered by the selected PHC. They included doctors, nurses, ANMs, female health supervisors and public health nurses.

STUDY AREA AND COMPONENTS

Our research was conducted in Medak, a backward and predominantly rural district of Andhra Pradesh. With a population of 2.65 million, the literacy rate in the district is lower than the national or state level, and stands at 34.8 per cent for females. Besides the district hospital that has 300 beds, Medak has nine small hospitals which together have a total of 278 beds. There are also 57 PHCs, 382 sub-centres and 68 private nursing homes and hospitals spread around the district.

Our study consisted of four components—the follow-up or prospective component, the community or retrospective component, service provider assessment

and facility assessment. Since the sample, site and instruments varied for all four components, each was conducted as an independent study, though the findings were pooled together for presentation and analysis. A community hospital (ZH) located on a major highway was selected for the follow-up component of the study, and three villages covered by a nearby PHC were selected for the community study. The final sample consisted of 40 women who have had abortions—13 of whom were chosen through community-based identification and 27 through hospital-based recruitment. The study also included 17 service providers and two health facilities—a hospital and a PHC.

Follow-up of Women after Abortion (Prospective Component)

Twenty-seven women who underwent abortion in a small government hospital were followed up for six months to assess the post-abortion services provided to them by government service providers. The women were recruited between March and August 2002 and followed up until March 2003. Each woman was interviewed four times.

First interaction:	Immediately after abortion at the hospital
Second interaction:	Two weeks after abortion at home
Third interaction:	Two months after abortion at home
Fourth interaction:	Six months after abortion at home

Study of Women in the Community (Retrospective Component)

A community-based study was conducted in three villages covered by a PHC located closest to the selected hospital. The three villages together had a population of 6,636. A house-to-house survey was conducted to identify women aged between 15 and 49 years, the childbirths and abortions they have had during the previous twelve months. Among the 1,494 married women who were identified, 143 had been pregnant during the previous twelve months. Among these, 16 women in the three selected villages said that they had had an abortion during the twelve months prior to the study. We could interview only 13 of these 16 women and part of this report therefore pertains to them. Although the sample is too small to arrive at any definite conclusions, it does provide useful insights into women's experiences and the quality of services at the periphery.

Service Providers and Facilities

Service providers were divided into two categories—hospital-based and field-based (PHC)—and cover four doctors, three staff nurses, nine ANMs and one health visitor. Facility assessment was done in the selected community hospital and PHC.

FRAMEWORK FOR ASSESSMENT OF POST-ABORTION CARE

The standard of care that should be provided to women at two weeks, two months and six months after abortion was formulated during workshops with the help of an expert group comprising gynaecologists, nurse–midwives and public health specialists. This group also reviewed the tools and examined the ethical and gender issues related to the study.

Tools for Data Collection

Based on the framework, interview guides were developed for interacting with women during each follow-up visit. Women from the three selected villages were interviewed with the help of another guide. A guide for interviewing service providers was also prepared and used for discussions with doctors, nurses, ANMs and health volunteers (HVs). A facility checklist was prepared and used for assessing facilities in the hospital and the PHC. Field investigators were trained in different topics related to pregnancy, its problems and the different types of abortion, methods of abortion, and post-abortion complications and care. They also received practical training in interviewing, counselling, maintaining privacy and confidentiality.

Ethical and Gender Issues

In order to ensure confidentiality and continuity, only one person—a qualified, senior ANM—was used throughout the six months for recruiting women. The purpose of the study was explained to the women and their consent for participation was sought *before* they underwent abortion. If they agreed to participate, they were observed and interviewed after the procedure. Their addresses were noted and the time and venue for follow-up visits were fixed. Privacy and confidentiality

Table 1: Framework for Post-Abortion Care and Follow-Up

Care Immediately After Abortion	*Two Weeks After Abortion*	*Two Months After Abortion*	*Six Months After Abortion*
Observe for bleeding per vagina: amount, consistency, colour, odour. Check vital signs – TPR, BP, pain. Check retraction of uterus. Observe abdominal distension. Observe signs of perforation such as increased pulse rate, pain and breathlessness. Give perineal care Administer analgesics and other medications as prescribed. Reassure the client. Check if urine is passed. Observe if there is any discharge from nipples. Arrange baby care, if needed. Reassure relatives. • Give post-abortion advice on perineal care, rest, sexual activity, family planning, diet, cleanliness. • Talk about review visit.	Take history of bleeding, fever, white discharge, foul smell, burning micturition, haematuria, and pain or distension of abdomen. Observe perineum. Give reassurance. Ask about doubts and give information. Reinforce messages on: Perineal care, rest, sexual activity, diet, cleanliness. Counsel on family planning. Refer for problems.	Find out about abnormal bleeding, white discharge and smell. Find out about abdominal pain and distension. Ask whether menstruation is started. Find out history of using any family planning methods and the type used. If not, ask when and what type she is planning to use. Counsel on use of family planning methods. Ask when she wants next child. Ask about doubts and give information. Give reassurance. Refer for problems	Find out about regularity of menstruation. Take history of amenorhea. Ask history of abortion or abnormal bleeding with discharge of products. Take history of chronic fever, burning micturition, abdominal pain and white discharge. Ask history of using any family planning methods and the type. Counsel on use of family planning. Counsel on risks of repeated MTPs. Ask when she is planning for next child. Refer for problems.

while visiting her home, and the use of masking and camouflaging methods were also discussed with the women and the accompanying persons.

To maintain confidentiality, women were divided into three groups: married women whose abortions were known to family members and even neighbours; women who have had an induced abortion (even those who are married) but did not want certain family members to know about it (the mother-in-law, for example); and those who fell into the 'sensitive' category and needed to be handled with utmost care. This last group comprised unmarried girls, widows and women separated from their husbands. In their case, only one staff member—the one who recruited the women—made all subsequent home visits using camouflaging methods. The follow-up visits were kept strictly confidential, with the field investigator being debriefed after each visit.

Follow-up became a problem in some cases when women gave incorrect or incomplete addresses during their first interaction with staff (immediately after abortion). We took this as an indirect indication that they did not want to be visited and so no further effort was made to contact them again. Two women went to their maternal homes for the abortion. When they returned to their marital homes, it was difficult to meet them without breaking confidentiality. Hence, follow-up was done only for 27 women, although 33 had initially consented to participate.

The data is presented in three parts:

- Findings from the women's perspective
- Responsiveness of the public health system to women who used abortion services
- Perceptions, practices and problems of service providers.

FINDINGS FROM THE WOMEN'S PERSPECTIVE

As mentioned earlier, our findings relate to the 27 women who were followed up for six months and the 13 women from three villages who had undergone abortion during the year prior to the study. Fifteen of the 27 women had undergone induced abortion (MTP) and 12 had suffered either bleeding or abdominal pain at home before they approached the hospital for treatment and complete abortion. Compared to this, all 13 women who were identified in the community insisted that they had had a spontaneous abortion. Because the three groups differed on several variables, such as age, order of pregnancy and period of gestation, they were dealt with separately. However, wherever possible, data on them has been integrated for the purposes of this report.

Profile of Women Who Underwent Abortion

Within easy access of nearly 100 villages, the government hospital selected for study was a referral hospital located on a national highway. The majority of women (19 out of 27) who came to the hospital for an abortion were from villages that fell within a 25 km radius of the town in which the hospital is located. One woman came from 100 km away because her mother lived near the hospital, and eight women came from other *mandals*.

Our research revealed that most of the women are poor, illiterate, landless labourers from socio-economically under-privileged communities. About half the women (14 out of 27) are illiterate and only two have studied above high school level. The majority are housewives or daily wage labourers. Only three work in their own farms or ply their own (petty) trade. Over 50 per cent (16 out of 27) belong to scheduled castes or tribes and seven are Muslims. Some data related to the profiles are given in Table 2.

Most of the women belong to joint families and live in one-room houses (17 out of 27). The household size is more than six in the case of half the women. Very few families have assets such as land. Only 12 own cycles or other two-wheelers. Some families own a few goats and

Table 2: Socio–Economic and Reproductive Health Profile of the Women

Socio–Economic Profile of Women	*Freq.*	*Reproductive Health Profile*	*Freq.*
Literacy and education		*Present marital status*	
Illiterate	19	Married	35
Primary education/just read/write	12	Widowed/separated	1
Studied up to high school	7	Unmarried	4
Studied above high school	2		
Occupation of women		*Age at marriage in completed years*	
Housewife	17	Less than 15	16
Daily wage labourer	18	15–17	7
Own trade/farm	3	18–20	8
Others	2	Above 20	4
Unmarried or missing information	5		
Occupation of husband		*Age at abortion in completed years*	
Daily wage labourer	17	Less than 20	5
Own trade/farm	9	20–24	11
Service/employed	8	25–29	7
Not mentioned/not applicable	6	30 and above	4
Caste		*Duration of pregnancy at the time of abortion in weeks*	
Scheduled caste	19	Upto 12	5
Scheduled tribe	4	13–16	11
Other backward castes	7	17–20	7
Others	8	More than 20	4
Religion		*Number of pregnancies*	
Hindu	19	First pregnancy	8
Muslim	9	Second pregnancy	6
Christian	10	Third or more pregnancies	13
Others	2		
Type of house		*Number of abortions*	
Kaccha	9	One	24
Pucca	8	Two	2
Semi-pucca	23	More than two	1
Number of rooms		*Number of childbirths*	
One room	18	None	11
Two rooms	15	One	4
Three rooms	7	Two or three	6
		Four or more	6
Household size		*Number of living children*	
Between 2 and 5	22	None	11
Between 6 and 8	14	One	4
Nine or more	4	Two or three	6
		Four or more	6

Box 1: Socio-economic status of women: SG and SF

SG's husband left her because she was not good-looking. She is an illiterate, scheduled caste woman currently living with her mother. SG's mother had to leave the comfort of living with her son to care for her abandoned daughter because SG's brother did not want them living in his house. They have rented a small room without electricity or water for Rs 100 per month. They take up whatever work is available, each earning about Rs 20 per day whenever they are fortunate enough to get work. But because SG was not able to work for many days after the abortion, they did not earn enough even to buy food. SG and her mother are worried that might have to move out of the rented room since it is becoming difficult to pay the rent. All they own are a few clothes and vessels.

SF is a 30-year-old Muslim woman with seven children. She and her husband are daily wage labourers. Besides vessels and clothes, they also own two goats. Their combined income is about Rs 70 per day if they get work. After she had the abortion, SF could not work for some days and the family did not have enough to eat.

a few have cattle for farming. Two families have sewing machines and are engaged in tailoring. A few families have a television set and a radio. Only five (JK, SR, RD, CK, MT) said they did not have day-to-day financial problems.

A similar picture obtains for the 13 women identified in the three villages. The majority belong to the lower socio-economic strata and have low education and income levels. Four women have completed primary education, while seven are illiterate. Most of the women and their husbands are daily wage labourers. Only four of the 13 women live in concrete houses, while five live in *kachcha* houses. Box 1 indicates the socio-economic status (using SG and SF as examples) of the majority of women who underwent abortion in the government hospital.

Age and type of abortion

More than 50 per cent (16 out of 27) of the women are below 25 years (Table 3). Women who underwent induced abortions are slightly older than those who had spontaneous abortions. The mean age of women who had induced abortions is 24.8 years compared to 21.5 years for those who had spontaneous abortions.

Table 3: Age and Type of Abortion

Age in Years	*Spontaneous Abortion*	*Induced Abortion*	*Total*
18 or younger	1	3 (unmarried)	4
19–24	8	4	12
25 and above	3	8	11
Total	12	15	27

Period of gestation and type of abortion

Two-thirds of the women (18 out of the 27) had the abortion in the first trimester (Table 4). Among the nine women who had it in the second trimester, five aborted between 13 and 16 weeks, three aborted between 17 and 20 weeks and one woman at 22 weeks. Three of the nine women who had abortions in the second trimester had induced abortions, whereas six had spontaneous abortions. Only three of the 15 women who had induced abortions delayed till the second trimester. There were more women who had induced abortions in the first trimester compared to those who had spontaneous abortions.

Table 4: Period of Gestation and Type of Abortion

Period of Gestation	*Spontaneous Abortion*	*Induced Abortion*	*Total*
Up to 12 weeks	6	12	18
Above 12 weeks	6	3	9
Total	12	15	27

Order of pregnancy, order of childbirth and number of abortions

For nearly one-third of the women (8 out of 27), the abortion was of the first pregnancy (Table 5). But for nearly half (13 out of 27) it was the third or subsequent pregnancy. Five of them had had five pregnancies. One woman (SF) was pregnant for the ninth time: she had seven living children and two induced abortions. Another woman (AS) was pregnant for the eleventh time

Table 5: Order of Pregnancy and Type of Abortion

Order of pregnancy	*Spontaneous Abortion*	*Induced Abortion*	*Total*
First pregnancy	4	4 (unmarried)	8
Second	4	2	6
Third or more	4	9	13
Total	12	15	27

Box 2: Why did women delay seeking abortion services?

All the women who had induced abortions stated that the pregnancy was unwanted, though for different reasons. The three who delayed obtaining abortion services till the second trimester gave the following reasons: pregnancy was not expected due to sterilisation, fear of social repercussions (AA, NM and SF) and high blood pressure.

AA did not expect to become pregnant since she had undergone tubectomy the previous year. She already had four children and did not want any more. When she observed the increasing abdominal size and other signs, she thought it was a tumour. She went around clinics and hospitals saying she had undergone tubectomy and now had a growth in her abdomen. The growth was confirmed as pregnancy when she was 14 weeks pregnant. The news was a shock to her. She did not know what to do. She was ashamed since she felt that pregnancy after sterilisation would perhaps be taken by others to mean that she is a promiscuous woman. Hence, she did not approach the ANM. Finally she spoke to her mother-in-law and went to the government hospital for abortion at 16 weeks.

NM is an 18-year-old unmarried girl from a scheduled caste. She developed sexual relations with a boy next door. She was afraid of the changes in her body and confided her fears to her sexual partner but he refused to accept responsibility. When things became worse, she was compelled to inform her mother. Her mother approached the boy and requested him to marry her daughter. The boy refused since he belonged to an upper caste. These negotiations took some time. NM and her mother went to the hospital when she was 16 weeks pregnant.

SF is a Muslim woman with seven children who works as a daily wage labourer and has a history of hypertension. She did not want any more children. She went to the PHC for oral pills but the ANM did not give them to her because her blood pressure was high. She went to the government hospital for a tubectomy, but here too the doctor advised her to wait till her blood pressure was normal. He gave her some tablets and asked her to come back again. In the meantime she conceived. She could not take time off for abortion since work was available at that time and she could not afford to forego the wages. She did not tell the ANM because she would not be of much help. She finally approached the government hospital for help when she was almost 20 weeks pregnant.

with four living children and seven induced abortions. Among the 12 women who had spontaneous abortions, it was the first pregnancy for one-third (4) of them, whereas amongst those who had induced abortions it was the third or subsequent pregnancy for nine out of 15 women.

Number of abortions per woman

Though most of the women (24) had undergone only one abortion, two had had two abortions each. In both cases, one was induced while the other was a spontaneous abortion. One woman had had seven induced abortions. Among the 13 women in the community-based study, 10 women had undergone one abortion each and three had had two or more abortions. One woman in the community (RM) had had three pregnancies and all three ended in abortion.

Number of childbirths/living children and type of abortion

Eleven of the 27 women who were followed up have not had a single childbirth (Table 6). Four women have one child each, six have two or three children each and another six have four or more children. In the case of women who had spontaneous abortions, only five of the 12 women have at least one living child. Among the seven women who have no living children, it was the first pregnancy for four women and second pregnancy for the remaining three. One of them (NB) had a stillbirth, the second had a neonatal death (SG) and the third (TJ) had two spontaneous abortions. On the other hand, all the 11 married women who had induced abortions have at least one living child. Women who underwent induced abortions appear to have more children compared to those who had spontaneous abortions.

Table 6: Number of Childbirths and Type of Abortion

No. of Children	*Spontaneous Abortion*	*Induced Abortion*	*Total*
No children	7	4 unmarried	11
One child	2	2	4
Two or three	2	4	6
Four or more	1	5	6
Total	12	15	27

Reasons for Abortions

The most common reason for induced abortion appears to be inadequate contraceptive information and

services (Table 7). Seven out of 10 women living in a marital relationship used abortion to space childbirths. All of them said that they had to abort their pregnancy because their last child was too young. Only three of these 10 women underwent abortion for other reasons, such as health problems, failure of tubectomy or reservations about the use of modern spacing methods. Another fairly common reason (5 out of 15) seems to be 'socially unacceptable pregnancy'. Four had abortions because their pregnancy was the result of an illicit sexual relationship and one girl was a victim of rape.

Table: 7 Reasons for Abortion

Reasons for Undergoing Abortion	
Poor spacing method due to inadequate services and information	7
Rape, premarital relationship, extra-marital relationship	5
Health problem, tubectomy failure or unwilling for tubectomy	3

Sex of child and abortion

No inferences about gender preferences can be drawn from the few women studied here. But in the case of four of the six women who underwent abortion for spacing, the last child was a daughter who was less than a year old (GM–5 months, MT–7 months, RD–8 months, ZB–11 months).

Conception after abortion

Eight of the 27 women became pregnant within six months after abortion. Six of them had had spontaneous abortions and wanted to conceive again. The remaining two had induced abortions. One was afraid she might become infertile if she waited too long and the second was a widow who could not use contraception because of her marital status.

Post-Abortion Problems and Complications

Most women faced complications after abortion. Seventeen of the 27 women said that they developed complications within two weeks of abortion. This number rose to 21 in the case of complications that occurred between two weeks and two months. And at the end of six months, three women still had problems related to abortion. Most women who faced complications said that they took action to deal with them (18 out of 21). Twelve went to a hospital or doctor for medicine and advice. In the case of the remaining six, a family member brought the medicines from either a doctor, health worker or healer.

Box 3: Socially unacceptable pregnancy leading to induced abortion

Five of the 27 women underwent abortion because their pregnancy was not socially approved. Among these, four are unmarried (PD, NM, BK and BM) and one is a widow (SM).

PD (18 years) developed a relationship with a married neighbour who is related to her. When she became pregnant, he told her not to reveal this to anyone. He approached a staff nurse living in their neighbourhood and she advised them to go to the government hospital for abortion.

NM (18 years), who has studied up to Class X, was staying at home while her parents worked in the fields because they could not afford to send her for higher education. She developed a relationship with a boy next door. The boy denied the relationship and refused to marry her. So her mother took her to the government hospital for abortion.

BK (20 years) had a boyfriend who belonged to a different caste. Both sets of parents refused to accept their relationship. When she became pregnant, her mother took her to the hospital for abortion because marriage was not possible.

BM was 15 years old and studying in Class VIII in the next village. One day, on her way back from school, four young men kidnapped her, took her to a field and gang-raped her. She was too shocked and afraid to tell anyone. Her mother took her to a private doctor for irregular periods. When the doctor confirmed BM's pregnancy, her mother was afraid to tell her husband, who was BM's stepfather. The doctor advised them to go to a government hospital for abortion because they could not afford her fee.

SV (28 years) is a widow with three children. After her husband's death six years ago, she has been living in her husband's joint family. She developed a relationship with her husband's married cousin who is their neighbour. When she became pregnant, the man did not want the relationship to be revealed. He accompanied her to the hospital for abortion. When she went to the government hospital, she did not reveal that she was a widow.

Box 4: Other reasons for induced abortion

Not ready for the next child—SR's case

SR is a graduate housewife with a two-year-old daughter. She wants to do her BEd and become a teacher. When she became pregnant again, she thought that the second pregnancy would hinder her from doing this. She convinced her husband and underwent abortion without informing the other family members.

Sterilised but pregnant—case of the confused and desperate AA

AA had undergone tubectomy after four children. As a labourer, she could barely feed her children on her earnings. The ANM of her village had taken her for tubectomy at a DPL camp. When her pregnancy was confirmed, she spoke to her mother-in-law and they went to the government hospital for abortion.

Desperate to get rid of unwanted pregnancy—GB's case

GB is a 35-year-old Muslim woman with four children (two boys and two girls). She did not want any more children but she was not using any contraception. When she was 12 weeks pregnant, she went to the government hospital and had a dilation and curettage (D&C) done. When the bleeding continued for over a week, she thought that the abortion was not complete and went to a private clinic and had the D&C done again. When she did not get her period for more than a month, she became anxious and went to a doctor in the city and had a third D&C done. At the end of six months, GB started using oral pills. She does not believe in sterilisation.

Seven induced abortions in 10 years—AS's case

AS is an illiterate, 35-year-old woman from a poor family. She works as a labourer. She has four children and did not want any more. The ANM visited her several times and advised a family planning operation. But she could not undergo tubectomy because the spirit of the goddess enters her frequently. On these days, AS falls into a trance (this type of hysterical behaviour called *Banamati* is common in Medak). She thought, '*What if the Goddess were to enter into my body during the operation? What would happen to me*?' She refused the operation and has an abortion whenever she misses her period for two consecutive months. Her husband does not want to undergo vasectomy. Other family members feel that she should undergo tubectomy.

Box 5: Examples of post-abortion complications

JD has three children (two daughters and one son). She wanted one more son. During the twelfth week, she had slight bleeding and went to the government hospital. The doctor performed a D&C. She had continuous bleeding for 15 days after the abortion, so she went back to the hospital where the doctor prescribed some medicines. When the bleeding did not subside, she was referred to the district hospital. But JD went to a private hospital and got treated because she did not think the government hospital would be capable of dealing with her problem. Six months later, JD was again 12 weeks pregnant and hoped to get a son.

SR had bleeding, white discharge and swelling of face and feet for two months after abortion. She went to a private doctor who suggested scanning and D&C. SR was afraid and went to her mother's place in the city for treatment. After the complications subsided, she became apprehensive about being infertile and was therefore anxious to conceive again. She did not use contraception. At the end of six months she was 14 weeks pregnant.

Infertility after abortion

SP was married at the age of 15 years. She gave birth to a girl child three years after marriage. But the child died six days after birth. After this, she had two abortions within a span of two years. She changed three doctors, in the hope of receiving treatment that would help her to conceive. It is now eight years since her marriage and she still has no children. Her sisters-in-law and other relatives accuse her of infertility and threaten her with her husband's remarriage. But the husband supports SP.

RK did not conceive even five years after her first delivery. The neighbours began saying that she may not conceive again. She approached the village *dai* (people believe that *dais* can treat infertility). The *dai* gave her some tablets and RK became pregnant. Unfortunately, the doctor told her that it was molar pregnancy and she had to be operated. Family members and friends were angry with her for approaching *dai* as they felt this was the cause of the abortion.

Box 6: Post-abortion contraception and reasons

Sterilisation for social reasons—case of SG

SG underwent tubectomy two months after abortion though she did not have any living children. She was separated from her husband and, according to her neighbours, was too poor to feed herself. Her mother and neighbours pressed her to undergo sterilisation since she did not have a husband. The operation was performed in the government hospital.

Oral pills after abortion—case of GB and RD

GB has four children—two boys and two girls. She did not want any more children. She started using oral pills. Unlike GB, RD has only two children—a son and a daughter. But the two-and-a half-year old son had not started talking yet and the daughter was less than a year old. She did not want to undergo sterilisation till the boy could speak and hence started using oral pills.

IUD after abortion—case of JK and MT

Both JK and MT have studied above high school and are from a middle-class background. Both had an IUD inserted at the government hospital because they were familiar with it. In the case of JK, her mother worked there. In the case of MT, her mother's house was next to the hospital and she knew the staff. JK did not want to undergo tubectomy because she felt that it would make her weak. She was trying to convince her husband to undergo vasectomy. MT wanted to delay the birth of her second child.

Post-Abortion Contraception

We assessed menstrual regularity, contraceptive utilisation and pregnancy status at two and six months after abortion for both groups of women (Table 8). The data revealed that only one woman was using contraception at the end of two months. She (GB) did not want any more children but also did not believe in permanent sterilisation. At the end of six months, only five more women were using contraception. Two started using oral pills, two had an intra-uterine device (IUD) inserted and one underwent tubectomy.

Abortion used as contraception

Six of the 15 women who had induced abortion used it as a spacing method. Four of them said that they underwent abortion because their last child was too young when they became pregnant again. Two have one child each (GM and MT), one has two children and one has four children. Two of them underwent abortion because the timing of the pregnancy was not convenient (SR) or because there was no help available for childcare.

Table 8: Use of Contraception after Abortion

Use of Contraception	*At the End of Two Months*	*At the End of Six Months*
Not using	26	14
Using	1	5
Pregnant	0	8

Reasons for not using contraception

Among the 14 women who were not using contraception at the end of six months, four are unmarried girls. Of the remaining 10, four want to get pregnant. One is scared of operations (AS, who gets possessed by the goddess). Some women like ZB, who have completed their desired family size, did not undergo sterilisation or use any other form of contraception because it is against their beliefs. ZB is a Muslim woman with four children. She feels that it is not right to use modern contraception. She prefers herbal medicines.

Cost of Abortion

Almost all the women selected the government hospital because they could not afford private hospitals and because they thought government services would be free (Table 9). But the doctors in the government hospital also charge a fee, though it is lower than in private hospitals. Case studies revealed that women found it difficult to find the money to pay for abortion and had to struggle to repay the loans taken for the purpose. The doctor's fee constituted 90 per cent of the abortion cost. Only two out of 27 women did not pay the doctor any fee.

The average fee for abortion in the government hospital is Rs 612 (Table 10). The average fee for spontaneous abortion is slightly higher (Rs 633) than that for

Table 9: Cost of Abortion and Type of Abortion

Fee Paid to Doctor	*Spontaneous Abortion*	*Induced Abortion*	*Total*
Below Rs 500	5	9	14
Above Rs 500	6	5	11
Total	11	14	25

Box 7: Reasons for not using contraception six months after abortion (n=14)

Want to get pregnant again

FB and SB had spontaneous abortions during their first pregnancy. TJ had a spontaneous abortion after the first and second pregnancies and has no children.

Want to have a male child

ST and TB had spontaneous abortions at their fourth and fifth pregnancies. They have one male child and more than one female child. 3

GM has one child (female). 3

Fear of social disapproval due to premarital, extra-marital sex, rape, etc.

BK, NM and PD had premarital sex. BM was raped and one woman was a widow. 5

Medical and other reasons

SF has high blood pressure. AA became pregnant despite tubectomy. AS has four children. She is a devotee of the Mother Goddess who, she claims, descends on her regularly. At such times, she is under the influence of the goddess and is unaware of herself. She is afraid to undergo tubectomy because the goddess might descend on her during the operation. ZB has four children (two boys and two girls) but does not believe in modern contraception. She wants to take some herbal medicine. But the medicine is supposed to be taken only after delivery. She could not take it after the last delivery and so had to get pregnant again. She had to abort the fifth pregnancy. She became pregnant within six months after the abortion and wants to continue the pregnancy till childbirth so that she can take the herbal contraceptive medicine after delivery. 4

Box 8: Economic burden of abortion

For AA: The total cost of abortion, including doctor's fee and treatment charges, was about Rs 1,250. AA's husband, who is a daily wage labourer, did not have the money. Her mother-in-law had to borrow it from the village headman. AA had to sell two goats to repay the money that her mother-in-law borrowed. The cost was high because they did not believe that she was pregnant and had to get scanning done in a private hospital to confirm pregnancy.

BM's mother is a labourer who was charged Rs 1,000 because her daughter was unmarried and therefore needed the abortion badly. Her pregnancy was a result of rape. BM's mother had to arrange the money secretly. She borrowed Rs 300 from the village *patel*, for which she paid 5 per cent interest. In addition, she had to sell her gold beads and BM's silver anklets. BM's mother earns only Rs 20 per day and is struggling to repay the loan. BM has had to discontinue her studies.

JB had to sell personal belongings like her watch and jewellery. She borrowed money from her brother-in-law at 10 per cent interest. It took her three months to arrange for the money. Due to repeated visits to the hospital for complications and treatment, JB's husband lost two months of work.

PR took two days to arrange for the Rs 1,300 required for her treatment. She had to take a loan on interest. PR complained she was not able to work after abortion.

MG said she borrowed money at 5 per cent interest and she was planning to work hard to save money to repay the loan.

RK is a DWCRA group member. She borrowed Rs 10,000 from the DWCRA women's group at 3 per cent interest. She has to return the money within six months. She is planning to repay the money by cutting down on family expenses. RK had to spend more since she also had an operation.

Table 10: Average Fee Paid in the Hospital

Cost of Abortion	*Amount in Rupees*
Average fee paid to doctor	612.00
Maximum fee to doctor	1,500.00
Average fee to *dai*	30.00
Maximum fee to *dai*	50.00
Average hospital charges	11.48
Maximum hospital charges	50.00
Average cost of medicines	145.74
Maximum cost of medicines	600.00

induced abortion (Rs 590). The maximum amount charged is Rs 1,500. Usually, the doctors' fees depend on the women's economic status and the intensity of their need for abortion. Bed charges are extra. Besides the doctor, the women also have to pay the *dai*, who usually charges Rs 30. The maximum amount paid to a

dai was Rs 50. The hospital nurse does not charge any amount directly. However, in two cases, the women said they paid her Rs 30, but then they did not pay the *dai*.

The hospital also levies a nominal charge of Rs 5 if the woman has to remain in the hospital for a short while; but this charge shoots up to Rs 50 if she has to stay on for a whole day. Four of the 27 women said they paid Rs 50 as hospital charges. On the whole, however, the average hospital charge paid by the women was Rs 11.48. The average travelling cost per woman was Rs 50 and the average amount spent on medicines was Rs 145.74. Barring one woman, who did not spend on medicines at all, the maximum amount spent on medicines was Rs 600 and the minimum Rs 50.

The cost of abortion services varied in all the 13 cases in the community study. The doctor's fee ranged from Rs 150 to Rs 2,760. The minimum cost was Rs 150 (this was the amount spent by a poor woman who used the services of a government hospital). One woman (PM) said that after paying the high fee for abortion, she could not afford a post-abortion check-up. Another woman (GY) said she could not have a complete check-up due to financial constraints. Because she could not afford private services, she was forced to put up with the rude behaviour of one of the hospital staff.

Most women had to borrow money at 5 per cent interest. Some had to sell their assets like jewellery and cattle. Apart from financial costs, abortion also affected the work, education and livelihood of the women and their families. Sometimes they lost their jobs due to absence from work. Women who were daily wage workers (such as SD and SG) suffered the most, because they could not work and earn to feed themselves and their families. Those who were engaged in petty trade lost the business after abortion.

Family Support to Women Undergoing Abortion

We found that when undergoing abortion, women generally turned to their husbands, mothers or mothers-in-law for support (Table 11). Twelve women said they first approached their husbands or sexual partners to discuss the problem before deciding on abortion. In some cases, the women approached their mothers (8) or mothers-in-law (6) for support.

Table 11: Family Support to Women Undergoing Abortion

Family Member	*Spontaneous Abortion*	*Induced Abortion*	*Total*
Husband or partner	3	9	12
Mother-in-law	4	2	6
Mother	5	3	8

Box 9: Support from husbands or partners

BK: The man helped financially but did not go to the hospital or visit her later.

PD: The married man bore the expenses and accompanied her to the hospital.

NM: The boy involved refused to help and even denied the relationship.

SV: She was a widow. The man bore the expenses and accompanied her to the hospital.

We found that husbands in nuclear families were more supportive, particularly when the women chose to have an induced abortion. Of the three women who were involved in a premarital relationship, two received some support from their partners.

In two cases (NB and SR), while the husbands were initially supportive, they turned against the women when there were complications. In the case of ZB, she did not inform her husband at all: *'I already had four children. I took the help of the ANM and went to the hospital. I told him afterwards.'* Husbands get upset if the abortion relates to a wanted child, particularly when it is spontaneous.

Mothers provided psycho-social and economic support even if they were not the first to know about the abortion. In the case of NM, the mother did not tell her husband about her daughter's premarital relationship; she lied and said that their daughter had abdominal pain because of a tumour. BK's mother also did not reveal BK's involvement with another man. The man gave them money and the mother managed the abortion. In the case of BM, who was raped, the mother managed the abortion and post-abortion complications without revealing anything to BK's stepfather. In SG's case, her father died and husband left her. Her brother refused to help. It was only the mother who took care of her, working as a daily wage labourer in order to provide for her 'unfortunate' daughter. In some cases, mothers-in-law are also supportive and play a key role in decision-making about abortion. In the case of AA, it was the mother-in-law who decided that she should undergo abortion when she became pregnant due to tubectomy failure.

RESPONSIVENESS OF THE PUBLIC HEALTH SYSTEM TO WOMEN WHO HAVE ABORTION

Facilities and Services for Abortion in Government Hospital

Two government health facilities were assessed for the presence of service providers, equipment and facilities for carrying out the abortion procedure. One of these is a block hospital (ZH) and the other is a primary health centre. The PHC has only one doctor and nurse, with no facilities to conduct MTPs. Our observations therefore pertain only to ZH hospital.

Abortion facilities and services

The hospital has three doctors—two female and one male. There are also three nurses who assist during abortion and provide immediate post-abortion care to patients. Though all three doctors conduct abortions, the majority of abortions taking place in the hospital are done by the senior male doctor who lives in the hospital premises. He performed 15 of the 27 abortions, while the two female doctors together did the remaining 12.

A total of 33 women were provided abortion services at ZH government hospital in the six months that the women were recruited. Abortions are conducted in the labour room of the hospital and registered in the maternity register. There is no specific consent form for MTP. Every patient who comes in for abortion has to pay the hospital a nominal charge of Rs 5, and Rs 50 if they have to stay overnight. The hospital does not supply medicines or food, which have to be bought from outside.

Most of the women said that they chose the government hospital because they could not afford to go anywhere else. However, follow-up data indicates that there were also other reasons. Many cited convenience, saying that the hospital is close to their homes (the majority of the women who accessed the hospital's services are from the town itself or from nearby villages). Some women used the hospital's services because they knew the hospital staff (7). Almost all said that they were too poor to pay for private services. One woman (RD) said that she felt comfortable with the female doctors in the hospital. According to another woman (SV), the fact that the hospital is located very far from her home made it possible to keep her abortion secret.

Six of the women were not asked to sign any consent form. In terms of services, pre-abortion cleaning and medication were provided to most of the women. However, none of them was asked to undergo a blood grouping or haemoglobin percentage test. Clean perineal pads and bed linen were provided to only four women. While most women expressed satisfaction with the abortion procedure and medication, they were not happy because they had to get medicines and food from outside. Lack of water was a major problem and all the women complained about the cleanliness standards of the hospital.

Initially, most women expressed satisfaction with the behaviour of the staff—doctors, nurses, *dai* and others—and said that they had been treated with dignity and respect. On further probing, however, more than 50 per cent (15 out of 27) admitted that they had not been treated with dignity. One woman was not happy with the behaviour of the doctor, three did not like the behaviour of the nurse, and five did not like the behaviour of the *dai*. For example, SG was not happy with the behaviour of any of the staff in the hospital. Although she was too poor to pay for the services and, despite being in pain, had come walking because she did not have money to pay for a rickshaw, the staff had insisted that she pay the hospital charges. Finally, SG's mother had to borrow money to pay the hospital and the *dai*.

Discharge advice and information

Most of the women were informed about the medications they were required to take, the need for rest, signs of post-abortion complications and the need for a review visit (Table 12), but very few were told about perineal care, diet and sexual activity. Only eight women were advised about contraception use after abortion (ZB, MT, SF, R, TB, GB, RD and SV). Of these, three began using contraception by the end of six months (MT, GB and RD). Three women were counselled about sexual activity.

Table 12: Health Advice Given to Women Before Discharge

Follow-up Advice Given Before Discharge	*Frequency*
Explained about medication	26
Explained about review visit to hospital	22
Warned about post-abortion complications	19
Advised adequate rest	16
Explained importance of perineal care	11
Advised about diet	9
Motivated for family planning	8
Counselled about sexual activity	3

Follow-up visit to hospital

Twenty-one women made follow-up visits to the government hospital after abortion. Of these, 17 said they went because they had health problems such as weakness, bleeding, abdominal pain and fever. Four said they went on the advice of the doctor. Another woman's (ST) mother, who worked in the hospital, took her there when her bleeding wouldn't stop. Six of the 27 women did not go to the hospital for follow-up after abortion. Most of them are unmarried girls who wanted to avoid unnecessary exposure. In the case of one unmarried girl (PD), her sexual partner got her some medication for abdominal distension from a private clinic.

In the community study, six of the 13 had their abortion at home while seven went to the hospital after bleeding started. All seven women said they received immediate treatment but only five said they were treated with respect. Six women had to undergo scanning. Three said that the doctor informed them about the necessity for abortion but not about its implications. Eight of the 13 women said that they had approached a service provider (government or private) at least once, either before or after abortion. Only one of the 13 women said that she preferred the village practitioner (*dai*) because she was more easily accessible.

Post-Abortion Services Provided by ANMs

Only three of the 27 women (AM, ZB and GM) were visited by an ANM within two weeks after abortion. In one case (AM), the ANM gave her medicines and asked her to visit the health centre. Another ANM accompanied a woman (GM) to the hospital. Only one woman (GM) approached the ANM for advice before seeking abortion.

Women's awareness about ANMs

Nearly half the women who had an abortion said that they were familiar with the ANM. Eight women did not know her at all and seven knew her but not her name. Among the eight who did not know her at all, five are from an urban area where ANMs do not make regular home visits. Among the other three (NB, SF and MT), two belong to a very low socio-economic group and one did not have any opportunity to interact with the ANM since she does not have any children. Of the seven women who were aware of the ANM but did not know her name, three are unmarried and therefore did not interact with the ANM. Two (TM and RD) belong to an urban area which ANMs do not visit often. Two (FB and SB) had no reason to interact with the ANM previously since this was their first pregnancy. And some women could not reveal their pregnancy because of their premarital or extra-marital relationships or rape.

Of the 13 women identified in the three villages, three said that the ANM had known about their abortion and had provided them with services. Three women did not know the ANM at all, five knew her but did not know the sort of services she provided, one said that the ANM had a good reputation. Three others were not happy with the village ANM, who, one of them said, is '*more interested in family planning operation cases and she visits houses only for that purpose*'. Another woman said that she had gone to the ANM for help but the ANM had refused to take up abortion cases.

Post-abortion service provided by ANM

Of the 27 who had their abortion in the government hospital, ANMs visited three women (AM, ZB, GM) within the first two weeks of the abortion, four (AM, ZB, GM, AA) between two weeks and two months, and two (GM, AS) between two and six months after the abortion (Table 13). Only GM was visited thrice. The ANMs checked them for fever, vaginal discharge, abdominal pain, bleeding and burning micturition. The women said that the 'sister' had enquired about their well-being, given them a physical check-up and reassured them. All of them said that they were happy with the ANMs' visits. One ANM offered to get the medicines prescribed by the hospital. Another gave advice about post-abortion care, diet and rest, and one advised the women she visited on family planning methods.

Table 13: Women Visited at Home by ANM

Visited at Home by ANM	*Within Two Weeks*	*Within Two Months*	*Within Six Months*
Yes	3	4	2
No	24	23	25

PERCEPTIONS, PRACTICES AND PROBLEMS OF SERVICE PROVIDERS

A total of 17 service providers were interviewed: four doctors, nine ANMs, three staff nurses and one health visitor. The service providers are from the hospital where the abortions were conducted, as well as the PHC where the community survey was done.

Box 10: Women who received post-abortion services from ANMs

GM received regular post-abortion follow-up care because her neighbour is an ANM. This ANM did not serve the area in which GM lived because her sub-centre was elsewhere. GM consulted the ANM because she did not get her periods after she gave birth to a baby girl seven months back. The ANM confirmed her pregnancy and spoke to her about the problems of poor spacing. GM and her husband decided to have an abortion. Since she lived in the same locality, the ANM accompanied her to the government hospital. The ANM visited her regularly after the abortion. Later, GM was referred for an IUD.

ZB consulted her village ANM, who regularly gave her family planning advice since she had four children. ZB's fourth child was less than a year old and she was 10 weeks pregnant. ZB claimed that the ANM gave her some tablets and then asked her to look out for bleeding. When she started bleeding, the ANM accompanied her to the government hospital and facilitated the abortion. The ANM gave her B-Complex tablets and advised sterilisation, but ZB declined the advice since this was against her beliefs. She said she would take herbal medicine.

AM was pregnant for the first time. She started bleeding at 16 weeks and went to the government hospital. She did not approach the village ANM. But when the ANM heard about the abortion during her visit to the village, she met AM and provided her with follow-up care and advice.

Of the four doctors, two have completed a postgraduate diploma in gynaecology, one has undergone MTP training and the fourth has experience in assisting abortions in a private hospital.

Providers' Awareness about Abortion and MTP

None of the ANMs are trained to provide MTP/abortion-related care. Five of them have been providing abortion care for the last six to seven years and have picked up the skills along the way. Five service providers said that they had received reproductive and child health (RCH) training during the last five years. Two staff nurses had undergone in-service training in clinical skill enhancement. One ANM had attended health visitor training as well as double puncture laparatomy (DPL) and integrated skill development training during the last five years. Four service providers were not even aware that there are different types of abortion. Only seven seemed to know of this, while eight were only aware about the indications for conducting an abortion.

All the service providers (except one) were aware of the instruments required to conduct an abortion. Only four knew about the package of services to be included in post-abortion care. They mentioned checking for bleeding, fever and white discharge, giving advice on personal hygiene, and recommending complete rest and family planning methods as post-abortion services.

Eleven out of the 13 non-medical service providers were aware of the MTP Act; the two ANMs did not know anything about it. Only two doctors could list the indications for MTP according to the Act. Three out of the four doctors did not know whether MTP services are included in the RCH programme.

Attitudes of Service Providers

The 17 service providers were asked key questions about their attitude towards women who approached them for abortion treatment and care. The questions dealt with women who are HIV-positive or single women, and other issues like consent from husband, abortion as a spacing method, etc.

HIV-positive women

Two of the four doctors said that since the women who come for abortion cannot afford an HIV test, doctors take their own precautions. One doctor said that if they know that a particular woman is HIV-positive, they do not provide her any service. The fourth doctor did not comment.

Women coming alone

Only five service providers said that some women come alone to get the abortion done, such as unmarried girls, promiscuous women and women with alcoholic husbands. Only four service providers said they would conduct the abortion even if a woman came alone. Among them three are doctors and one is an ANM. The ANM said she would accompany the woman to hospital. Ten service providers said that they would not conduct an abortion if the woman came alone.

Single women

The majority of service providers (11) said they would not conduct abortion for single women, including separated/widowed/unmarried women. They said that an abortion might block the fallopian tubes and the woman may not be able to conceive again. Others said that they would conduct the abortion because if they did not, the women would just go elsewhere.

Husband's authorisation

Most service providers said that they insist on obtaining the husband's permission to conduct abortion to avoid any backlash from the husbands later on. Only four said that it is enough for a woman to be accompanied by a responsible person.

Abortion as spacing method

Almost all service providers said that abortion is not an appropriate spacing method. On the other hand, about half (8) of them said abortion could be used as a spacing method once or twice but not repeatedly. Three said that abortion is a convenient method of family planning compared to the other methods available.

Abortion after sex determination

The majority of service providers (14), including doctors, said abortion should not be permitted if sex determination tests are done. But three said that this test should not be used to deny abortion services to women.

Women's Rights, Choice and Access

Ten service providers, including doctors, do not perceive abortion as a woman's right. However, all the four doctors said that the MTP Act has given women freedom of choice. They feel that this has reduced the number of illegal medical practitioners and hence the number of complications. Two doctors said that the MTP Act has facilitated abortion services for women. Another doctor said that it has raised the number of illegal pregnancies.

On further discussion, almost all the service providers said that MTP services are not accessible to women, particularly since they come at a high financial cost. Women's access to safe abortion services is also hindered by other problems, such as ignorance, social and economic instability, large family size, illiteracy, poverty, reservations against using family planning methods, health problems, preference for male children, prenatal sex determination and domination by husbands. Three of the four doctors agreed that women should have legal access to abortion, as well as the right to sue in case of complications. Two doctors said that apart from rape victims, the MTP Act does not mention separated women, widows or unmarried girls. As such, it has not really helped women.

Preferred place for MTP services

Six out of 17 service providers said women do not like to access MTP services at the PHC or the first referral unit (FRU) because they want to maintain confidentiality about abortion. Five service providers said that PHCs do not have adequate MTP facilities. Only two recommended that abortion services be provided at the PHC level.

Role of non-allopathic service providers

None of the service providers are in favour of non-allopathic practitioners offering abortion services. Seven said that since they are not trained, their services might lead to infection and risk to life. Two service providers said that the government should ban non-allopathic, non-medical and local medical practitioners from conducting abortions.

Role of mid-level providers

Thirteen of the 17 service providers said that ANMs should be trained to provide MTP services, as the ANM is close to the community and can be accessed easily by women. Four (two nurses and two ANMs) said that only doctors should conduct abortions. Another four said that if, along with ANMs, *dais* are also trained to conduct early abortion, abortion services would be more easily accessible to women in villages. About half of the non-medical service providers said that the nurse's main role is to assist the doctor during abortion and provide the patient with post-abortion care.

Abortion-related Practices

Doctors as abortion service providers

Although all three doctors (two female and one male) at the hospital performed abortions, the male doctor conducted more abortions than the two female doctors combined; he also performed more induced abortions (Table 14).

Box 12: Doctors at the hospital

Dr UK is a gynaecologist with 16 years' experience. Besides working in the government hospital, she runs a private clinic at home and is a visiting doctor in a nursing home. Dr UK does not think that abortion is a woman's right. She says that it is just a necessity at times. She conducted eight of the 27 cases followed up in this study.

Dr SH has seven years' experience as a doctor. She is not a gynaecologist and has not undergone MTP training. She runs a private clinic at home besides working in the government hospital. But she does not conduct abortions in her private clinic. She takes up abortion cases of up to 20 weeks' gestation. She conducted four of the 27 cases followed up in this study.

Dr RN is a senior male doctor. He is not a gynaecologist. He lives in the hospital premises and conducts deliveries and abortions regularly. He conducted 15 of the 27 abortions in this study. His fee ranges from Rs 300 to Rs 1,500. He insists on being paid before conducting the abortion. In NM's case, he gave her an injection and refused to do a D&C until NM's mother went home and brought him his fee. He charges less (Rs 300) if the women are referred by other doctors (JK). However, his fee is higher for unmarried cases: though BM was raped, he insisted that her mother pay him Rs 1,000.

Table 14: Abortions Conducted by Sex of Doctors and Type of Abortion

Sex of Doctor	*Spontaneous Abortion*	*Induced Abortion*	*Total*
One male doctor	4	11	15
Two female doctors	8	4	12
Total	12	15	27

Abortion-related practices of ANMs

Only four of the nine ANMs said they knew of women who had undergone abortion at ZH hospital during the study period. Eight out of nine ANMs made follow-up visits to the women who had undergone abortion. Six ANMs said they provided follow-up to all women and two said that they followed up only those women who had consulted them for abortion. During the follow-up visits, ANMs said they check the woman for temperature, BP, bleeding and abdominal pain. Only two ANMs said that they had advised the women on sanitation and hygiene. All of them claimed that maintaining confidentiality is a major problem because ANMs are associated with antenatal care and people become suspicious if a non-pregnant woman is seen with an ANM. They also said that women do not speak freely with them, even though the ANMs are willing to listen and provide services.

ANM 'VL' as an abortion service provider

VL has been living in BPL village for the last six or seven years. After completing the ANM course, VL worked in a private hospital and gained experience in conducting deliveries and abortions. Later, she started her own clinic in BLP village. BLP is a sub-centre headquarters village with 500 households. With no other health service provider in the village, she has gained a reputation for conducting deliveries and abortions. Most women from BLP and the surrounding villages come to VL for antenatal care and deliveries. Out of the 13 cases interviewed in the community for abortion practices, we found that one woman (RM) had gone to consult VL about her oedema during the sixteenth week of pregnancy. VL examined her, gave her an injection and asked her to come back the next day. RM started bleeding and went back to her. VL performed the abortion, gave her two more injections and medicines, and told her that everything would be all right. She charged Rs 500 for her services.

Dai as an abortion service provider

In another village, an experienced *dai* conducts abortions on a regular basis. She does not give any injections but uses her hands to gently massage the abdomen. Many women come to her for abortion because they believe she has special skills. One of the 27 cases that we followed up for six months (AS) went to this *dai* for five consecutive abortions. But the *dai* refused to help her after the fifth abortion. She suggested a family planning operation instead.

DISCUSSION AND CONCLUSIONS

This study is a qualitative, multi-component assessment of the perceptions, problems and experiences of 40 women who have had abortions (27 from a government hospital and 13 women from three villages) and 17 service providers. The women who had their abortion at the government hospital were followed up several times

Table 15: Abortion Services Provided by Doctors

Issues	*Responses of Doctors (n=4)*
Preferred method of abortion	Three of the four doctors prefer the D&C method up to 12 weeks of gestation. One doctor prefers vacuum aspiration. All doctors prefer the intra-amniotic induction method for aborting pregnancies of 13–20 weeks' gestation.
Medication for inducing abortion	Three doctors said that they use Prostaglandin injection to induce abortion. One doctor said she gives Syntocin tablets to induce abortion. All doctors said they use curettage after abortion to check for completeness of abortion.
Use of anaesthesia	All doctors said they use local anaesthesia, irrespective of the length of gestation. They use general anaesthesia only when necessary. Three doctors said that they themselves administer local anaesthesia with the help of a nurse.
Tests done before abortion	All doctors said that they prescribe HB and urine tests and, if the patient can afford it and is willing, they also ask for blood cell count test, grouping, HIV and blood sugar tests. Three doctors said they conduct the HB test before discharging the patient. One doctor said s/he checks the PV. Another said s/he checks for passage of urine and effect of sedation.
Drugs prescribed after abortion	All four doctors said they prescribe antibiotics for one week to prevent infection. They also prescribe antispasmodic and anti-inflammatory drugs. Two doctors said they also give B-complex tablets for one week to help the patient regain strength. One doctor said she gives analgesics and Styptovit tablets to help women expel leftover clots.
Follow-up care	Doctors mentioned that they advise personal hygiene and regular use of medicines to women before discharge. Three also advise the patient about family planning methods. One tells the women not to have sexual intercourse for five days. All doctors advise women to come within one week of abortion for follow-up. They said that 90 per cent or more women come for follow-up if asked.

for six months after the abortion to record their post-abortion experiences and elicit information about follow-up services provided by the public health service providers. Interviews were held with 13 women from three villages of a nearby PHC, all of whom had had an abortion during the twelve months preceding the study. Seventeen service providers working in the selected hospital and PHC were interviewed for their perceptions and practices.

The findings clearly indicate that there is:

- Low utilisation of government facilities for MTP by women
- Extremely low post-abortion follow-up by public health staff (ANMs)
- Use of abortion as spacing method
- A fee for abortion even in the government hospital.

Utilisation of Government Hospitals for MTP Services

Only 33 women used the hospital facilities during the six months of study (27 of these were followed up), averaging out to just about six abortions per month. Among the 13 women interviewed in the community, only four had their abortions done in the government hospital. This indicates that the government hospital is not their preferred facility for accessing MTP services. Statements by service providers support this fact.

Our data also show that the government hospital is used mainly by women in the town and from surrounding villages located within a 25-km radius of the hospital. Only one woman travelled about 100 km to this hospital because her mother lives nearby. Further enquiry revealed that there are only four other government hospitals in the district that provide abortion services to some extent. This indicates very low coverage by the public health system.

In conclusion, it can be said that two categories of women use the government hospital for abortion services:

(a) those who are too poor to go anywhere else;
(b) those who know someone working in the hospital and/or live nearby.

Confidentiality factor

Service providers felt confidentiality plays a definite role in the extent to which government health facilities are used. However, despite needing to maintain strict confidentiality, five of the 27 women followed up in this

study sought the services of the government facility. Within the village, ANMs as well as women felt confidentiality is an important factor in seeking the ANM's services. Because ANMs are associated with pregnant women, it is difficult for unmarried, widowed and abandoned women to go to them.

Cost of abortion as a factor

Most of the 27 women said they could not afford private hospitals and had thought that the government hospital would provide services free of cost. Though it initially seemed that the government hospital caters to the poor and underprivileged, this was not the case. Even the poor have to pay the doctors in the hospital for the services they receive. Only those who come through other doctors or know someone in the hospital are given some concession. Sometimes the women are placed under great stress because of the fee they have to pay.

Quality of abortion services

The women in our study did not find the quality of care offered by the hospital to be satisfactory. They complained about the rude behaviour of the hospital staff, which they have to tolerate because they cannot afford to go anywhere else. Women accepted the lack of facilities, such as water, as something normal.

Clearly, the government hospital needs to increase its outreach, particularly since the PHC does not provide abortion services and because there are only four other government hospitals in the entire district that provide these services with any regularity. This is extremely inadequate for a rural population of about two million.

Low Post-Abortion Follow-up by Public Health Staff (ANMs)

Only three of the 27 women who had their abortion in the government hospital were visited at home within two weeks by an ANM. Only one woman received the required follow-up three times because the ANM concerned lived next door. Even if concession is made for those who live in urban areas, the number of women receiving post-abortion care was negligible. Considering that 10–15 per cent of maternal deaths are accounted for by women who have abortions, the lack of follow-up after abortion is a cause for concern. There are several factors that contribute to poor post-abortion follow-up and care.

Women's low awareness of ANM's role

The ANM is associated with pregnancy and family planning. Women go to her for antenatal registration and tetanus toxoid injection. They are not aware of her role in providing abortion-related services. The fact that she is associated with pregnancy hinders unmarried women, widows and divorced women from seeking her services.

Non-availability of ANM

Since ANMs do not live in the villages they service, they are not easily accessible. The lack of bonding between them makes the women unsure about approaching ANMs on confidential matters like abortion. One woman approached a nurse (who works at the government hospital) living in the village because she provided abortion services regularly. But she did not approach the village ANM. The distancing between the ANMs and women who underwent abortion is clearly illustrated by AA's case. AA, who conceived despite a tubectomy, did not inform the ANM even though the ANM herself had taken her to get the tubectomy done.

Limited and unclear role of ANM in abortion services

The role of ANMs has been limited to only identifying and referring woman who need abortion. Since they do not play an active role, this aspect has not been given priority. When one woman with abdominal pain and bleeding approached the ANM for help, the ANM refused saying she did not deal in abortions.

Poor linkages between government hospital and primary health system

These two units of the health department operate independently. The hospital itself does not have regular outreach and follow-up services for women who have had abortions. Neither does it network with the public health system to ensure treatment, care and follow-up.

Use of Abortion as a Spacing Method

Abortion was used as a family planning method by most women who had induced abortions. Most of them women for abortion because the previous child was too young (less than a year) or because they had completed their desired family size (four or more children). Out of the 15 women who had induced abortions, only six had started using a family planning method even at six months after abortion. This indicates a strong need for

contraceptive awareness and services, especially spacing methods. There is also need to re-examine the state's approach to family planning:

- What does the public health system offer women like GB or ZB, who have already completed their desired family size but do not want to undergo sterilisation? Both have four children each—two boys and two girls.
- How can SF who has seven children but cannot use oral pills or tubectomy because of high blood pressure be helped?
- How can AS, who is afraid to undergo a tubectomy even after seven abortions, be persuaded to use some method of family planning and avoid pregnancy?
- Why is the public health system unable to help women like SG? She was very young, married, abandoned by her husband and did not have a child. She underwent a tubectomy because of pressure from her neighbours, who said that she would not be able to feed a child.

It appears that the state's family planning programme needs to focus more on providing women with information and counselling. The women need to be offered choices other than just tubectomy; in particular, they need to know more about the IUD and its advantages. Facilities for high-quality IUD services should therefore be created.

Charges for Abortion in Government Hospitals

Twenty-five of the 27 women had to pay for abortion in the government hospital, even though these services are supposed to be provided free of charge. This unofficial payment is responsible for most women seeking services from private nursing homes and hospitals. A major chunk of the money paid comprises the doctor's fee. About a quarter of the amount is used for medicines, bed charges, payment to the *dai*, etc. Women said that the amount they would have to pay for abortion in a private hospital is nearly three times that charged by the government hospital. In one case, the private doctor herself referred the woman to the government hospital because the family could not afford her fee. In this context, should the government doctors be excused because they are providing services to the poor at a lower cost, even though it is unethical of them to charge any fee at all?

The women seeking abortion services at the government hospital were so poor that they had to borrow money to pay the hospital, and some even had to mortgage or sell whatever little assets they had. One woman, who lived by making *bajjis* that her husband then sold in the market, suffered a severe financial crisis when she could not do any work after abortion.

It is interesting to note the variation in the fees charged by the three doctors in the hospital. The male doctor charged all 15 women who came to him, but his average fee was Rs 563.30. Compared to this, one of the female doctors who attended only eight women charged an average fee of Rs 637.50. The second female doctor who attended four women charged an average fee of Rs 875; but she did not take anything from two of the four women because their financial condition was very poor.

Health Burden due to Abortion and its Complications

Three women had health problems even six months after abortion. The inadequacy of post-abortion care provided by the public health system resulted in the women approaching different health facilities. One woman approached a healer for post-abortion complications. When post-abortion complications occur, women tend to lose faith in the doctor who had performed the abortion. One woman had a D&C done three times because she did not receive adequate post-abortion services and counselling.

Recommendations

The role of mid-level and peripheral service providers needs to be re-examined and expanded. The most common problems in the context of providing proper post-abortion care are maintaining confidentiality and the reluctance on the part of the women to express their problems freely. To overcome such problems, there is need to:

- Increase awareness among women and men about the availability of safe and free abortion services in the public health sector.
- Increase access to abortion services at the FRU level through better-quality services and control of unofficial fee collection.
- Organise better linkages between the hospital and its outreach services so that each woman is visited at least twice after abortion.
- Increase awareness among adolescents regarding reproductive health and safe sex to prevent socially unwanted pregnancies. Access to contraceptives must be improved irrespective of marital status.

- Sensitise couples towards family planning.
- Recognise the sexual rights of single women.
- Factor confidentiality into the provision of abortion services by the public health system.
- Improve management of post-abortion complications in the facilities where abortion services are provided.
- Plan and implement an effective and sustained strategy for promotion of spacing methods.
- Provide service providers with training oriented towards making them more sensitive to women's needs.

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Processes and Factors underlying Choice of Induced Abortions

Rural Tamil Nadu

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INTRODUCTION

Abortion was legalised in India by the Medical Termination of Pregnancy (MTP) Act of 1971. Since then, a number of studies have been published on the incidence of abortions within and outside approved medical facilities; on the nature, distribution and quality of abortion services; on the characteristics of women seeking abortion services from approved and unapproved sources; and on abortion-related morbidity. A systematic review of this literature shows that most abortion seekers were in the 20–34 age group, were married and had not used a method of contraception prior to the pregnancy that was sought to be terminated (Johnson 1999; Agarwal 2000).

Only a small number of studies have ventured into areas beyond mortality and morbidity, contraceptive use and demographic profiles of abortion seekers. Some of these have examined the decision-making process to terminate pregnancy among married women, and their findings suggest that it is invariably the woman who makes up her mind to terminate a mistimed or unwanted pregnancy. She then consults her husband and a joint decision is taken by both to seek induced abortion (Singh and Singh 1991; Parivar Seva Sanstha 1999; Sinha et al. 1998; Gupte et al. 1997). The abortion is usually kept a secret from the father-in-law and mother-in-law. In one study (Singh and Singh 1991), over 50 per cent of the women who had induced abortions had also consulted friends and relatives before making a final decision. Sinha et al. (1998) found that the husband's approval played a significant role in whether or not a woman was able to terminate an unwanted pregnancy. However, several women above 30 years of age who had experienced repeated pregnancies and did not have their husbands' support, had gone ahead with the abortion despite their disapproval or without their knowledge.

In all these studies, women were using abortion to space births or prevent an additional birth. Many of those who did not want any more children underwent sterilisation along with the abortion. However, those who had terminated a mistimed pregnancy rarely accepted a reversible method of contraception after the abortion.

Why do women undergo induced abortions rather than use contraceptives to space or limit births? Could it be that, rather than being an indicator of women's exercise of their reproductive rights, induced abortions signify their lack of reproductive and sexual rights? This would certainly be the case when women are disallowed from using contraception and cannot say no to sexual intercourse. But it is also possible that women may be using the threat of an unwanted pregnancy as a bargaining chip to negotiate a space within which they can accept or refuse sex.

There may also be a number of simpler explanations for the low use of reversible methods, such as women's lack of adequate knowledge about their safety, and the limited availability of methods and information through the government's family planning services. Another reason could be that women may have stopped using reversible methods following adverse side effects and are therefore forced to rely on induced abortions for spacing. Or, again, they may have been using ineffective methods, or effective methods incorrectly, leading to contraceptive failure.

We know relatively little about the reasons and processes that lead to women's choice of induced abortion to space births. We also do not know whether changes in indicators of women's status, the wider social acceptance and high levels of use of birth control measures over the past decades have made any difference to the extent of reliance on abortion for birth spacing. Such information is vital for the planning of interventions to prevent unwanted pregnancies if they are to have any significant positive impact on women's health.

The present research study was undertaken to explore the extent to which induced abortions are a result of women's lack of power to control sexual and reproductive decisions within marriage, and of gender power dynamics between couples in general. In the light of the dramatic decline in fertility levels and widespread social acceptance of contraception that have come about over the last two decades, the study also aimed to examine changes, if any, that may have taken place in women's ability to prevent unwanted and mistimed pregnancies.

THE RUWSEC STUDY

The study was carried out by the Rural Women's Social Education Centre (RUWSEC), based in Kanchipuram district of Tamil Nadu. RUWSEC is a grassroots women's organisation that has been working on women's reproductive health and rights issues since 1981. One of its activities is to promote contraceptive choice, and disseminating information to women and men on a range of reversible methods is a part of this effort.

The finding that even as late as 2002, the use of reversible methods of contraception was below 7 per cent posed a considerable challenge to the organisation. For almost two decades now, a large number of women have continued to use induced abortion either for regulating or limiting children, despite significant changes in the levels of female education, women's assertiveness and their access to information through the media. What is more, the decrease in the number of children desired is perhaps contributing to a greater demand for abortion services.

This is despite RUWSEC's efforts at disseminating information on reversible methods of contraception through workshops for women and men and for adolescent girls. RUWSEC has published and widely disseminated in its project villages, pamphlets written in simple Tamil on various reversible methods. These pamphlets address questions that women and men in the project area usually ask about the method concerned. The organisation distributes condoms in the community and has made a concerted effort to promote condoms among men. Oral pills and the intra uterine device (IUD) are also available at RUWSEC's clinic at no cost.

This study was therefore initiated to explore the factors and processes that underlie induced abortions, with the ultimate goal of designing community-based interventions to prevent unwanted pregnancies, based on an in-depth understanding of the processes leading to married women's choice of abortions to space births. Funded by the HealthWatch Trust, New Delhi, India, the study was carried out during 2002.

The research questions posed by the study were:

- What role do gender power relations within married relationships have in the choice of induced abortions to space births?
- How has this role changed during the course of a generation of major changes in the social, economic and demographic contexts?
- Are there differences in the gender power relations between couples who are 'ever-users' of induced abortion and those who are 'never-users' of induced abortion?

'Gender power relations' within marriage were defined to include:

- the nature of communication between couples—whether the relationship is a sharing, friendly one or one where the husband is the 'superior' partner;
- women's freedom of movement;
- women's role in making everyday decisions related to the running of the household and their children;
- the role women play in decisions regarding money matters;
- the freedom women have in deciding whether and

when to have sexual relations, the number and spacing of pregnancies and the use of contraception; and
- women's freedom from violence or threat of violence.

'Changes' during the span of a generation in gender power relations and their role in the use of induced abortion were sought to be captured by including, as study participants, two generations of married couples.

Study Area

The study covered 98 hamlets in Thiruporur and Thirukazhukundrum blocks of Kanchipuram district, Tamil Nadu, which also constitute the project area served by RUWSEC.

Tamil Nadu is among those states in India that have witnessed a rapid decline in fertility since the early 1980s. While between 1970 and 1979 its total fertility rate changed only marginally, from 4.1 to 3.8, it plunged to 2.4 by the end of the next decade and reached close to replacement levels in the mid-1990s (IIPS 2000). All sections of the population have experienced large fertility declines, desire fairly low family sizes and show low fertility (Appendix 2, Table 8).

However, unlike Kerala, where below-replacement fertility rates go along with low infant and child mortality rates, Tamil Nadu has achieved its near-replacement level fertility at relatively high rates of infant and child mortality. At 51 per 1000, Tamil Nadu's infant mortality rate in 1998–99 was about 2.5 times (20.9 per 1000), and its child mortality rate, at 14.3 per 1000, almost three times (5.3 per 1000) that of Kerala (NFHS–II).

In terms of economic development, the growth of Tamil Nadu's state domestic product in 1981 and 1993–94, the period of its fertility transition, ranked second only to Maharashtra. However, Tamil Nadu also had 35 per cent of its population living below the poverty line in 1993–94, ranking eighth from the top among the 16 major Indian states (Appendix 2, Table 9). In other words, relatively high rates of economic growth coexisted with substantial poverty.

Despite relatively high rates of female literacy and female work participation in Tamil Nadu, indicators from NFHS–II (1998–99) call into question the assumption that women in Tamil Nadu enjoy a high status or autonomy. For example, the proportion of women suffering from anaemia in Tamil Nadu (56.5) is higher than the national average (51.8 per cent), and 14 per cent of the pregnancies in the state do not end in a live birth, as compared to 9 per cent for India. Twenty-nine per cent of the women have a body mass index of below 18.5 kg/m^2, as compared to 16.9 per cent in Punjab and 18.7 per cent in Kerala. Almost 40 per cent of the women do not take decisions related to their own health. Forty per cent of the women in Tamil Nadu reported being beaten or physically mistreated since age 15, and 16 per cent said they had experienced the same in the twelve months prior to the survey. Both these figures are above the all-India averages of 21 per cent and 11 per cent respectively (IIPS 2000).

According to estimates based on NFHS-I data (1992–93), Tamil Nadu had the highest rate of abortions (spontaneous and induced) among Indian states (Appendix 2, Table 10). Even today, induced abortion rates in Tamil Nadu are the highest among Indian states, including Kerala, which has also achieved replacement level fertility. It is believed that a large proportion of induced abortions are reported as spontaneous. If true, this would mean that the induced abortion rate is even higher (Mishra et al. 1998). The widespread use of abortion as a method of birth spacing was also evident in a study on fertility transition in Tamil Nadu carried out by one of the authors (Ravindran 1997).

Kanchipuram district, where the present study was carried out, is a coastal district located very close to the state capital, Chennai, and accounts for 5 per cent of the state's population. Data on reproductive health for the unbifurcated Chengalpattu district (of which Kanchipuram is a part) are available from the rapid household survey carried out as part of the Reproductive and Child Health (RCH) Project in the state during 1998–99 (PRC et al. 2001). According to this survey, about 95 per cent of the rural population of the district receive full antenatal coverage, and there is little variation by caste (SC/ST and others) or level of education. Eighty-seven per cent of currently married women in the age group 15–44 years know of all the modern methods of contraception, and 90 per cent or more know about the condom, the oral pill and the IUD. Among rural women, 81 per cent have knowledge about all modern methods of contraception, while this figure is 74 per cent among women who are illiterate. The high levels of information notwithstanding, at 54.4 per cent, the district ranks tenth among the 23 districts in Tamil Nadu in terms of contraceptive prevalence rate. Of these, 49.3 per cent have undergone sterilisation, and only 0.3 per cent are male sterilisation whereas 49 per cent are female. Only 3.5 per cent of the women use modern, reversible methods

—IUD (2.6 per cent), pills (0.3 per cent) and condoms (0.5 per cent) (PRC et al. 2001).

RUWSEC works mainly with the *dalit* community and its project area includes those hamlets within larger villages where *dalit* households reside, as well as some poor hamlets of the 'most backward castes'. According to RUWSEC's database, the population covered by its programmes included 6,861 households and 30,125 persons in 1996–97. Ninety per cent of the population belonged to scheduled castes and the remaining 10 per cent were from 'other backward' castes. The sex ratio was 985 females per 1000 males and the average household size was 4.40 persons. The overwhelming majority of the population (97.4 per cent) was Hindu.

Low-income and socially marginalised, over three-fourths of the households were landless, with agricultural wage work being the main occupation for men and women. Housing conditions were very poor, with nearly 75 per cent of the households residing in mud huts with thatched roofs, 36 per cent without electricity and 93 per cent dependent on public water sources for drinking water (taps, open wells and irrigation pumpsets). Only four households had toilet facilities within their homes. The literacy rate for the population aged 7 and above was 59 per cent for males and only 40 per cent for females.

There were, in 1996–97, 4,117 currently married women who had not yet reached menopause. About 10 per cent of them were 40 years of age or more, and 4 per cent were between 15 and 19 years. The average number of pregnancies per woman was 2.9, and the average number of live births per woman was 2.5. An analysis of the number of pregnancies and live births by age indicates that only 13 per cent of women under 30 had four or more live births, as compared to 41 per cent of women over 30 years of age. Since most women complete childbearing and adopt sterilisation by age 29, this may be viewed as an indicator of a significant decline in the average number of children born.

There was a high rate of pregnancy loss. About 71 out of 1,000 pregnancies did not end in a live birth: 45 out of 1,000 pregnancies were either miscarried or aborted, and 26 ended in stillbirths. The not-so-encouraging pregnancy outcomes were despite reasonable levels of medical care during pregnancy and/or delivery: 80 per cent of all pregnancies were covered by some form of antenatal care, and 61 per cent of the women had been immunised against tetanus and undergone a medical check-up. About 50 per cent of the deliveries took place in a health facility—17 per cent had elected to have an institutional delivery and 33 per cent were referred by the traditional birth attendant (TBA) after the onset of labour because of complications or because the woman was considered 'at risk'.

Fifty two per cent of the 4,117 women (2,119) had adopted a method of contraception. However, use of modern spacing methods was still very low—less than 3 per cent (1.3 per cent on oral pills, 1.3 per cent using IUD and 0.2 per cent using condoms). Four per cent of the women reported practising periodic abstinence for spacing. Ninety-three per cent of those who had adopted a method of contraception had undergone tubal ligation. The proportion of women whose husbands had undergone vasectomy was only 0.7 per cent.

Thus, although the study covered a socially and economically marginalised population group, the profile of the population in terms of contraceptive behaviour was not very different from that of the general rural population of the district.

Methodology

Sample selection

This was a qualitative study, consisting of in-depth interviews.

The sample was drawn from two groups of women and their husbands.

- *Older women*: Ever-married women who had completed childbearing (were either menopausal or had undergone sterilisation) and had adult children (above 18 years).
- *Younger women*: Ever-married women below 35 years who had not undergone sterilisation as yet.

Within each group, equal numbers of 'ever-users' and 'never-users' of abortion were selected. Since RUWSEC has a fairly comprehensive database on its project villages, this was used to select a systematic, random sample of 'never-users' of abortion. There were 1,491 'young' and 656 'older' women such never-users. A 10 per cent sample for the younger women and a 20 per cent sample for the older women were selected and a village-wise list of women to be interviewed in the 'never-users' category was prepared. The sample was selected randomly to ensure a reasonably diverse group of study participants who represented a range of socio-

economic and demographic characteristics within the largely homogenous community with which RUWSEC works.

Ever-users of abortion were identified through several methods. One, from RUWSEC's database, the names of women who had voluntarily reported having undergone an induced abortion during routine data collection drives. RUWSEC's village health workers as well as some of the ever-users who consented to be interviewed also suggested names of others who were willing to be interviewed. The husbands of women selected for the study were interviewed with the consent of the women.

In all, the intention was to interview 60 women and 40 men. The 60 women were to include 30 'young' and 30 'older', divided equally between 'ever-users' and 'never-users' of induced abortion. Fewer men than women were included in the sample to allow for the possibility that not all women would agree to their husbands being interviewed, or have husbands currently living with them. The final sample consisted of 66 women and 44 men.

Research team

The research team consisted of nine members: four males and five females, including two senior research advisors, two researchers trained in demography and five field investigators. The field investigators were senior community health workers of RUWSEC and had considerable experience in carrying out workshops and training on gender and reproductive health and rights issues within the community from where the data was collected. Two of the investigators had carried out focus group discussions and in-depth interviews for other studies in the past, and had considerable knowledge of women's reproductive health issues in the local area.

Development of interview guidelines

Guidelines for the in-depth interviews were developed through an iterative process. It started with a brainstorming meeting with the coordinators and project officers of RUWSEC to identify major questions to be included. Based on this meeting and the study objectives, eight different interview guidelines were developed, one for each group of study participants: ever- and never-users of induced abortion, and men and women in two age categories.

The guidelines were reviewed and revised several times after discussions with the field investigators and a few external reviewers. They were then pilot-tested with 15 persons. Finally, the research team had a meeting with the ethics committee members to finalise the guidelines and methodology for the study (see section on Ethical Considerations for details on the ethics committee).

The final guidelines had eight major sections:

1. The socio-economic characteristics of interviewee and her/his spouse; and their household characteristics
2. Marriage
3. Decision-making within the household
4. Conjugal life
5. Pregnancy and childbirth
6. Birth control
7. Perspectives on induced abortion
8. For ever-users of abortion: decision-making process and abortion experience.

Fieldwork

The fieldwork began with orientation and training in methodology and ethical issues. Data collection was spread over four months, during which the team met once every fortnight to plan fieldwork, share issues and get clarifications.

It was decided to do the fieldwork in seven rounds, covering six to eight villages located within a geographical cluster in each round. This strategy was deliberately chosen to provide the team with some leeway in case a person or persons scheduled to be interviewed on a particular day were not available—they could then easily go to a nearby village and try their luck there!

Each interview followed three steps.

Step 1

The women field investigators went in pairs to a particular village with a list of 'never-user' women to be interviewed and met them in their homes. In the case of ever-users, the field investigators met the RUWSEC's village health worker, who contacted the women and obtained their permission for the investigators to meet them.

Step 2

After ascertaining their willingness to participate in the study, a time and place for the interview were fixed with each participant.

Step 3

The field investigators met the study participants as per their appointment and carried out the interview.

Before starting the interview, the investigators read out the aims and objectives of the study that were included in the consent form and obtained the participant's signature. For those who were unable or unwilling to sign but were interested in participating, the signatures of witnesses who could attest that this was the case were obtained.

The time and place for the interview were chosen according to the interviewee's preference. Almost all the participants preferred to be interviewed in their own homes, mainly due to time constraints. The infrequency of bus services in the area meant that coming into the RUWSEC office for the interview would take up an entire day.

The women were interviewed first. After completing each woman's interview, the investigators would request her consent for her husband to be interviewed. And only if the woman agreed did the investigators meet with her husband to ascertain *his* willingness. Women and men were interviewed at different places and at different times, the women by female investigators and the men by male investigators. Thus, there was no possibility of the information given by one partner being inadvertently communicated to the other. The investigators were allocated villages in such a way that none of them had to carry out interviews in her/his own village.

The interviews, which were detailed and open-ended, were not tape-recorded. Instead, the investigators took down notes during the interview, which were fleshed out the following day, while the details were still fresh in their minds. On an average, each field investigator could complete six interviews in a month. Each interview took about an hour-and-a-half to two hours, and most were completed in one sitting. Only in two or three cases was it necessary to have two sittings. The fieldwork was planned in such a way that two days of interviews were followed by three days of writing up. After transcription, each interview took up about 50–60 pages in the local language (Tamil).

RUWSEC had already established a good rapport with the study participants through its various community-based activities. The investigators' familiarity with the community and the fact that this was a RUWSEC study helped the team to complete the data collection work with relative ease and the fieldwork was completed on schedule.

During the data collection period, the research officers made supervisory visits to monitor the process and ensure data quality. Senior research officers also visited two villages during this period.

Each transcript was read several times by three persons (researchers and senior research advisors). The transcripts were then summarised, translated into English and stored in the computer as Word documents. Each interview was given a unique code number and a separate file name. The English version also slotted the information contained in the interviews into the eight major sections defined by the guidelines.

A master grid (Appendix 2, Table 11) was then prepared, with each column representing one major theme of the study and the rows representing individual respondents. A table was prepared for each of the eight categories of respondents, and summaries corresponding to each topic were placed within the grid. This facilitated the analysis, as it helped to get an overview of the main findings under each category, along with any differences across the younger and older categories, women and men and never-users and ever-users of abortion. A second grid (Appendix 2, Table 12) was also prepared with information pertaining to each couple placed one after the other along the rows, and divided into four tables corresponding to younger, older, ever-users and never-users of abortion. The second grid helped to get an overview of concurrence or discord in couples' statements about different issues.

Ethical considerations

Anyone undertaking a study on induced abortion would be faced with some tough dilemmas relating to the identification of women who have had abortions, and to planning the collection and management of data without violating ethical norms.

Since RUWSEC does not have an in-house ethics committee, a special one was set up for the study, comprising two women and three men. Two of the five were social scientists, two locally based social activists, and one a public health specialist. The names of the committee members are listed in Appendix 1.

There were two meetings of the ethics committee. As mentioned earlier, in the first meeting, the interview guidelines were submitted to the committee members

for their approval. They also reviewed the contents of the written consent forms. During the second meeting, the members scrutinised some of the interview transcripts and discussed with the field investigators the procedures followed for identifying study participants and the ethical dilemmas involved. Committee members from the local area made three spot-checks during the data collection period to ensure that ethical norms were not being violated.

It was decided that the following norms would be adhered to during data collection and management:

- The study team members would not ask anyone to give prior information on the identity of those who had undergone abortions, but would request them to ascertain the willingness of such persons to participate in the study before revealing their names.
- Informed consent would be obtained from all study participants. An effort would be made to obtain written consent, with participants having the option of withdrawing from the study at any stage. For those whose literacy skills were limited or those who could not read, the investigator would read out the contents of the consent form, which would include a description of the study and its aims and objectives. If a respondent was willing to participate in the study but unwilling to sign the form (this sometimes happens because of the fear of 'signing' written documents), the signature of a witness would be obtained attesting to the participant's willingness.
- The respondents' identities would be protected through the use of codes. No person or village would be named in the transcripts, thereby ensuring that no person other than the interviewer knew their identity. Data entered into the computer would be similarly protected.
- The place and time of interviews would be fixed in consultation with the interviewee. When interviews were fixed to take place in the community, privacy would be ensured during the interview by choosing an appropriate location.
- Interviewers from a specific village would not be entrusted with conducting interviews in their own village.
- Husbands would be interviewed only after obtaining the consent of their wives.

These norms were strictly followed while identifying and interviewing participants. No name was recorded anywhere in the study or the transcripts. Most interviews were conducted in isolated places in the community or in participants' homes, to ensure privacy. Interviews with women were carried out first. Their husbands were interviewed only with their approval and after all the interviews with women in a given village had been completed. No couples were interviewed successively.

Despite these precautions, there were one or two incidents where the respondents were upset with the research team. In one village a respondent (who was a never-user of abortion), shouted at the investigator, saying: *'Who gave you my name to interview? I am not "such" a person to answer your questions.'* The reference may have been to the aims and objectives of the study, which were first shared with a potential respondent in order to obtain her/his consent to participate in the study. In another village when, during an interview, the investigator asked questions relating to sexuality, the respondent suddenly got angry and withdrew her participation, tearing up the notes taken by the investigator. There were four women who withdrew from the study halfway through their interviews. A few men and women said: *'Sexual matters are something very personal. How can we share this with you?'* However, there were also women, including those who had undergone induced abortions, who approached the investigators volunteering to be interviewed.

FINDINGS

Socio-Demographic Characteristics of Study Participants

There were 110 respondents in all—66 women and 44 men. They included 44 couples and 22 women who did not want their husbands to be interviewed. All 44 men were husbands of the women interviewed.

Of the 66 women, 34 had had one or more induced abortions in their lifetime (ever-users) and 32 had never had an abortion (never-users); 23 of the 44 couples were ever-users and 21 were never-users.

Fifty-five respondents—23 men and 32 women—belonged to the 'younger' category, which included women who were 35 years of age or less and who had not yet stopped having children, and their husbands. The other 55 participants—34 women and 21 men—belonged to the 'older' category, which comprised women aged above 35 years with adult children, and their husbands.

Table 1 summarises the socio-demographic charac-

Table 1: Socio-Economic Characteristics of Participants

Characteristics	*Women*						*Men*					
	Young			*Old*			*Young*			*Old*		
	EU	*NU*	*TOT*	*EU*	*NU*	*TOT*	*EU*	*NU*	*TOT*	*EU*	*NU*	*TOT*
Mean Age	27.44	25.06	*26.25*	39.17	40.94	*40.00*	32.58	29.00	*30.87*	49.09	47.30	*48.24*
Religion												
Hindu	13	16	*29*	16	16	*32*	10	11	*21*	10	10	*20*
Christian	3	0	*3*	2	0	*2*	2	0	*2*	1	0	*1*
Caste												
Dalit	15	16	*31*	16	14	*30*	12	11	*23*	10	9	*19*
Other	1	0	*1*	2	2	*4*	0	0	*0*	1	1	*2*
Land-owning Status of Household												
Landed	3	8	*11*	6	5	11	4	7	11	4	5	9
Landless	13	8	*21*	12	11	23	8	4	12	7	5	12
Family Type												
Nuclear	7	8	*15*	14	12	26	6	4	10	8	7	15
Joint	9	8	*17*	4	4	8	6	7	13	3	3	6
Household Size												
Total persons	94	80	*174*	108	80	*188*	63	59	*122*	69	53	*122*
Average	5.88	5.00	*5.44*	6.00	5.00	*5.53*	5.25	5.36	*5.30*	6.27	5.30	*5.81*
Schooling												
No schooling	6	8	*14*	9	12	*21*	2	2	*4*	4	4	*8*
1–5 years	5	3	*8*	8	2	*10*	4	6	*10*	4	4	*8*
6– 8 years	1	2	*3*	1	2	*3*	3	2	*5*	1	1	*2*
9–12 years	3	3	*6*	0	0	*0*	2	1	*3*	2	1	*3*
Degree	1	0	*1*	0	0	*0*	1	0	*1*	0	0	*0*
Occupation												
Agricultural wage labour	8	12	*20*	12	12	*24*	5	4	*9*	8	5	*13*
Own farm work	1	3	*4*	4	2	*6*	3	1	*4*	0	3	*3*
Other wage labour	1	1	*5*	0	0	*0*	0	5	*5*	0	0	*0*
Not working outside home	4	0	*1*	1	2	*3*	0	0	*0*	0	1	*1*
Others**	2	0	*2*	1	0	*1*	4	1	*5*	3	1	*4*
Average Age at Marriage	18.56	17.56	*18.06*	16.56	16.25	*16.40*	22.58	22.36	*22.48*	22.82	20.30	*21.62*
Pregnancy												
Total	65	41	*106*	113	72	*185*	-	-	-	-	-	-
Average	4.06	2.56	*3.31*	6.28	4.50	*5.44*	-	-	-	-	-	-
Children Ever-Born												
Total	41	29	*70*	83	66	*149*	-	-	-	-	-	-
Average	2.56	1.81	*2.19*	4.61	4.13	*4.38*	-	-	-	-	-	-
Total	*16*	*16*	*32*	*18*	*16*	*34*	*12*	*11*	*23*	*11*	*10*	*21*

Note: ** include salaried employment, trading and vending.
EU = ever-users of abortion; *NU* = never-users of abortion; *TOT* = total.

teristics of the study participants. The majority of the participants were Hindus; only eight were Christians and all but seven belonged to the *dalit* community. Thirty-eight per cent (42 out of 110) of the participants came from households that owned some land, while 62 per cent were from landless households. The average household size was 5.51, and 5.38 and 5.64 respectively for the younger and older group of respondents. Around 60 per cent (66 out of 110) of the participants lived in nuclear families, with the remaining 40 per cent living in joint families.

The average age of women respondents was 26.3 years and 40 years respectively for the younger and older groups. For men, the average age was 30.9 years and 48.2 years respectively. The mean difference in age between couples was a little less than five years for the younger age group and a little more than eight years for the older age group.

There was a wide difference by sex in the proportion of persons with schooling. Only 56.3 per cent of younger women and 38.24 per cent of older women in the study had some schooling. Among men, 82.61 per cent of the younger group and 62 per cent of the older group had attended school.

The majority of the women and men participants were agricultural labourers. They usually had an average of three to six months of regular work in a year, and their daily wages ranged between Rs 25 and Rs 40 for women and Rs 50 and Rs 100 for men. When agricultural work was not available, they sought work as unskilled manual labourers. Although two-fifths of the participants owned some land, the size of landholding was very small and income from cultivation was not enough to sustain a household. Members of households with small holdings were often engaged in other occupations in order to supplement the household income.

There was approximately a year's difference in the average age at marriage between younger and older age groups. The average age at marriage was 18.06 and 16.41 for younger and older women respectively, and 22.48 and 21.62 for men.

The average number of pregnancies among younger women was 3.31, while it was 5.44 among older women. Similarly, the average number of children ever born to younger women was 2.19, and to older women, 4.43. Ever-users of abortion reported a slightly higher average number of pregnancies, as well as children ever born, in both age groups. In the younger group of women, abortion users had an average of 4.06 pregnancies and 2.56 children ever born, as compared to an average of 2.56 pregnancies and 1.81 children ever born to women who had not used abortion. In the older age group, the comparative figures were 6.28 pregnancies and 4.61 children ever born among abortion users, and 4.5 pregnancies and 4.13 children ever born among never-users of abortion.

Marriage

In the rural setting in which this study was based, the majority of marriages are arranged by families. However, the consent of prospective brides and grooms is usually taken into consideration. When a marriage goes ahead without the consent of one or the other party, it is likely to affect communication between the couples, which in turn can have implications for sexual and reproductive decision-making.

This is not to say that 'love' marriages are problem-free. 'Falling in love' is still forbidden behaviour in the study area, and young people rarely have an opportunity to get to know each other in normal circumstances. They often rush into marriage, as they see this as the only way of spending any time together, or because a marriage is being arranged for one of them, and sometimes because the woman is pregnant. When a marriage takes place in such circumstances, the woman may lose all parental support, which in turn may place her in a vulnerable position within the marriage.

Thirty-five of the 44 couples had had their marriages arranged by their families. There were also nine 'love' marriages. Seven of the 'love' marriages were in the younger age group, and only two were in the older age group.

Fourteen of the 44 couples were related to each other before marriage. Among the 35 arranged marriages, eight women and two men reported being forced into the marriage. In one marriage, neither party had wanted to marry the other. One man had been compelled by his family to marry a bride of their choosing. The remaining seven women said that they had not consented to the marriage, whereas their husbands did not say this. There was one dramatic instance of a woman being coerced into sex by her betrothed before the marriage, and her subsequent refusal to marry him because of sexual violence was over-ridden.

'Love' marriages took place in varying circumstances. In three instances, the couples were related to each other,

and although there was initial opposition from their families, they had married with their parents' consent. Five couples had eloped and got married without family support, and among three of them, the woman was pregnant at the time of marriage. One marriage was between a widow with two children and a friend of the family. Their marriage had been arranged by the woman's family despite stiff opposition from the man's family, because she had become pregnant by the man. The marriage was performed under a court order.

Dissatisfaction with the state of their marriage was expressed by 12 wives (but not their husbands), one husband (but not his wife), and one couple. All those who reported a forced marriage were unhappy with the marriage even after several years. Two women who had had 'love' marriages also said that they had unhappy marriages.

Household Decision-making

Overall, men dominated in household decision-making and were responsible for all important decisions. Some husbands consulted their wives when taking major decisions, but in no instance could a wife take independent decisions except in trivial matters. The most commonly heard response regarding household decision-making was the stereotypical '*men decide money matters and women decide on household matters*' (16 out of 44). In the case of 11 couples, all decisions were made by the husband; in-laws were the main decision-makers in two instances; women alone took all decisions in the case of two couples. Only five couples reported that they took decisions jointly. There were several (9 out of 44) instances where the wives and husbands interpreted the women's roles differently, with the wives expressing dissatisfaction at their lack of decision-making authority.

Of the 16 couples who claimed that the husbands took all the major decisions, 10 were in the younger category. Among them, the women could decide on some day-to-day matters:

> I can buy things for myself like flowers, clothes and groceries. Only during festivals and such major occasions does he buy household items. (YWEU–8)

> In my household I take decisions about money matters and important matters like purchase of dress and jewels during festivals, etc. She can decide on her own to buy things of daily need for the household, and about children's health. (YMEU–7)

However, this was not simply a matter of division of responsibilities. Among most of these couples, women could not spend money on any major purchases without their husbands' permission. They could not go out on their own. In some cases, but not all, they could take their children to health facilities without being accompanied by anyone. Many women and men mentioned that they/their wives never went anywhere without the husbands' permission, conveying that this was appropriate and approved behaviour. Participation in the public sphere was not possible without their husbands' permission, and was often disallowed.

> I have to get his permission to go out. Otherwise he will beat me. I was interested in joining the village self-help group. He was not there, and I went to the meeting without telling him. He beat me terribly for this, so I did not join the group. (YWNU–13)

Unilateral decisions by the man in all matters was reported by both husband and wife in 11 of the 44 couples. In these instances, the women had no say in running the household. Five of these were younger couples, and six were older.

> I take decisions in my family. I will not allow her to take any decisions. She cannot have any money of her own, if she has I take it away. I have beaten her for her wrong decisions. So, she never takes any decisions. (YMNU–7)

> He decides all matters in my household. I never say anything. What is there to say? He is my husband, he decides. (OWNU–6)

> He takes all decisions. I didn't even purchase a sari for myself during the five years of my marriage. One day, when I took my son to hospital without his permission because he was not there, he abused me: 'You, an eloped donkey, how dare you (*odi vantha kaluthaikku enna theriyum*)?' I have to ask him to accompany me even for small things, like going to the bathroom at night. Otherwise he calls me a prostitute. (YWNU–4)

One young woman narrated how her father-in-law was the decision-maker in all matters. But she was no meek onlooker:

> In my family, my father-in-law takes all decisions. Even

> for my personal things and problems, he takes the decisions (jewels, money, dress, flowers, etc.). Once, when I objected, he scolded me and shouted, 'Shut your mouth and be a woman.' (YWEU–2)

Two women, one in the younger and the other in the older age group, said that they made all the important decisions and not their husbands, who were alcoholics and did not support the family.

Among nine couples (four younger and five older), men and women viewed their decision-making roles differently. While the men said that they always consulted their wives and that decision-making was done jointly, the women felt that they did not have an equal say in any matter. The wives also resented the restrictions on their mobility and the need to seek their husbands' permission for almost everything. For example, according to one husband:

> In my household we both take decisions jointly with due consultation. She can buy flowers, dresses and other things for herself. Regarding borrowing or lending money, we both take the decisions. . . . We both jointly make decisions about children's health and future. (YMEU–2)

However, his wife said:

> Usually he takes decisions in my family. He never considers my view in the decision-making process. I have to accept his decisions even to buy things for myself like flowers, clothes. He never bothers about the children's future and education. For example, yesterday I borrowed some money from my mother and bought notebooks for the children. He never thinks about it. (YWEU –5)

According to a man who has been married for 23 years:

> We both take decisions jointly, with mutual consultation, particularly on matters like purchasing land, loan, household items, etc. We never take decisions unilaterally. (OMEU–4)

But his wife had a different tale to tell:

> I cannot take any decision because he is a drunk and shouts at me if I decide anything without his knowledge. I have to get his permission to even go to places like my natal or relatives' home. (OWEU–5)

As mentioned earlier, only five couples of the 44 (three younger, two older) interviewed said that they took joint decisions. One husband said:

> In my household, I ask her consent in all of my decisions. Similarly, she asks my opinion in her major decisions. But about purchasing household things and small matters she decides on her own. We both decide on matters relating to children's health and future. (YMNU–4)

His wife agreed:

> We both jointly decide all matters. But I am the implementing authority of all decisions. I can buy things for the household and myself and decide money matters also. I can go out with his permission. (YWNU–7)

A 50-year old-man, who has been married for 25 years, said:

> I never take any decision without my wife's knowledge. Usually, we both discuss before finalising decisions relating to money and property matters. (OMEU–10)

His wife corroborated this:

> Even money matters we discuss jointly and come to a common agreement/conclusion. (OWEU–12)

Overall, a slightly smaller proportion of younger (5 out of 23) as compared to older couples (6 out of 21) had men taking unilateral decisions. There were also fewer younger (4 out of 23) than older (5 out of 21) couples where the wife reported that she was not consulted in decision-making while the husband said that decisions were made jointly.

Sexual Relations within Marriage

Talking about sex and expressing desire

Even though sexual desire is common to both men and women, the vast majority of women (54 out of 66) stated that they did not talk about sex with their husbands, or express their sexual desire in other ways. Contrary to the women's statements, 29 out of 44 men in the study said that they openly spoke about sexual matters with their partners. Only four couples out of 44 said that they were able to talk freely about sexual matters, and all but one of them were younger couples.

The women often gave a stereotypical response: *'How can women talk about sex?'* Except for seven women who had had 'love' marriages and had experienced sex before marriage, all the women had learnt about sex within

marriage. One older woman said she had not known about sex even after several months of marriage:

> I didn't know about sex before marriage and I have never spoken about sex with him. Even after marriage we hadn't 'joined' (had sex) for six months because of I was fearful and shy. (OWEU–2)

Most women said that they had sex whenever their husbands wanted. Some said that they felt shy even to look at his face the morning after a night of sex. This was true even for women who had had 'love' marriages, and those who had become pregnant before marriage:

> We were lovers and had sex before marriage. As a result of that I conceived before marriage. I don't talk about sex with him; this is something secret and happens only in the night. So how can we talk about these things openly? (YWEU–12)

But there were a few women who not only felt free to talk about sex but also to express their desire to their husbands:

> I didn't know about sex before marriage. But I can now talk about sexual matters openly. If I have the desire, I tell him. He accepts and we have it (sex). Sometimes when I call him he says, 'I am not interested now; we will have it tomorrow.' Similarly I can tell him if I am not interested. We mutually respect each other and do things that we like. (YWNU–7)

As has been mentioned earlier, in general men reported that they felt free to talk about sex and express their desire to their wives. All but three of the 44 men said that they were able to express their desire to their wives. One of the men who could not express his desire was an older man who said that since he was no longer employed, he did not have (the authority) any power to call his wife for sex.

According to another older man:

> I never speak about sex with her because we both feel shy about it. Whenever I have sexual urge, we have it (sex). (OMEU–1)

The third was a younger man who did not think that talking about sex was appropriate:

> I don't talk about sex with her. How can we speak these things in a village? Whenever I have the feeling I have it (sex). She never says no. When I call her she pretends that she is not interested. But she is happy when we have it. She never expresses her sexual desire. (YMNU–2)

Many of the older men complained, however, that their wives no longer liked their husbands talking about sex and desiring sexual relations.

> I like to speak openly about sex. I used to speak those days but now she does not like it because we have adult sons and daughters. (OMNU–5)

Non-consensual sex

Non-consensual sex was highly prevalent in the area. Among 56.8 per cent of the couples (25 out of 44), the women (17) or both partners (8) stated that the woman could not refuse if her husband desired to have sex. Six men also talked about their inability to take no for an answer when it came to sexual matters. Many of the women whose husbands were not included in the interview (15 out of 22) had experienced non-consensual sex. Overall, 40 women reported non-consensual sex, with their experience ranging from being nagged into submission to outright sexual violence.

One commonly heard comment from most women was that if they refused, the men abused them verbally and asked: *'If not me, who do you want to sleep with?'* This appeared to be a routine threat to cow women into submission.

In its mildest form, non-consensual sex led to the woman feeling humiliated and resigned to her fate. Several women reported that *'they would lie like an inanimate object, like a piece of wood, while he went ahead'*. There were other instances reported, however, that were far more serious and involved physical abuse. A woman who has been married for 18 years said:

> Sex is a regular event for him—a regular habit like chewing betel leaf. If I object, then he will hurt me by saying, 'Do you have someone else? If not with me, whom do you have it (sex) with?' If he decides to have sex, he won't leave me. He will have it no matter what—even during my menstrual periods.
>
> If I don't want to have sex I have to act as if I am not well (lie in bed, calling out in pain). Then he accepts. I can use this technique only on rare occasions. I don't love him; I have only fear and hate. (OWEU–)

Women were also forced into having sex under threat of their husbands seeking sexual pleasure elsewhere.

Nine men (out of 44 couples) had one or more sexual partners besides their wives.

> Sex is a regular event for him; he has it daily before he goes to sleep. Whenever I say no, he beats me and says, 'I will go in search of another woman.' (YWNU–5)

> He has extramarital relations and I once rejected his desire because of fear of getting infection. That time he beat me badly. He had sex by force and said that even if he had sex with a thousand women, he got something different from me. (OWEU–14)

In several instances where the wives reported sexual coercion, the men concerned tended to report being considerate and always engaging in consensual sex. But there were a few men (9) who admitted that they would not accept 'no' for an answer. According to them:

> She doesn't object to sex usually, and I have it as I wish. If she objects when she is not well or when she is menstruating, I accept it. But if she objects for other reasons I don't accept it and will have it by compulsion without her desire. I beat her in two situations. One is when I am drunk and other is when she says no to sex. (YMEU–2)

> Many times my wife had expressed her reluctance because she was afraid of getting pregnant. I didn't accept her rejection because I was unable to control my feeling. I would force her into sex saying, 'What is wrong if you conceive again?' Mostly, I was under the influence of alcohol and that affected my judgement (*kudi kannai marachidum*), but I would feel bad in the morning for my harsh behaviour. (OMEU–7)

Sexual violence in the context of other forms of partner violence

Sexual violence within marriage is embedded within a larger context of the use of physical violence or threat of such violence to keep women submissive. Nineteen of the 25 women who reported non-consensual sex spoke of regular or routine sexual violence. But there were an additional 11 women who reported other forms of intimate partner violence, bringing the total number of couples reporting sexual or other forms of violence to 36 (out of 44). Of the 66 women interviewed, 47 reported experiencing violence: 40 reported sexual violence and seven reported other forms of intimate partner violence.

There were some interesting differences between the reporting of violence by women and men. Some partners of women reporting sexual violence admitted to both coercive sex and physical violence. However, in almost every case, the men portrayed the reason for violence as a domestic disagreement relating to the wife's inadequate performance of her duties:

> She doesn't care about children's neatness. I beat her for that, and for not preparing the food when I am hungry, and sometimes for not cleaning the house. (YMEU–3)

> I beat her because she quarrels with my mother. (YMNU–8)

Further, the data analysis revealed that unless it was extreme, women tended to under-report violence that was not sexual. For example, in eight of the 11 couples reporting non-sexual violence, it was the husband who reported that he often beat his wife when he was drunk or because 'she answered back', whereas the wife did not report experiencing any violence from her husband. The sort of non-sexual violence that women did report had to do with quarrels relating to the husband's extramarital affairs, routine drunken abuse and extreme forms of cruelty.

> He beat me with his shoes. I had delivered only two weeks ago, and he was angry that I had delivered a third girl child. (YWNU–13)

Within such a context of violence, couples can hardly be expected to communicate or relate with each other on equal or easy terms. This lack of communication plays out in the extent to which women are able to have a say in matters related to the regulation of their fertility.

Sexual rights

Despite the reality in which they live, there were few women who believed that men had a right over women's sexuality. But they regretted that for many women, it is not possible to exercise their sexual rights.

> Women should have the right as to where and when to have sex. I am a slave. How can I exercise my rights? (YWNU–5)

> It would be good if women have decision-making powers regarding sex. But this is not possible in my life. (YWEU–6)

No man would accept the notion that women have the

> right to decide whether and when to have sex. It will not work in a majority of women's lives. (OWNU–13)
>
> I have the right to decide whether, when and where to have sex. But generally men view women as childbearing machines. (OWNU–10)

Pregnancy and Childbearing

The pregnancy experience

The women included in the study had had an average of 4.41 pregnancies each. But there were differences between the younger and older age groups in the number of pregnancies and childbirths. The average number of pregnancies among the younger women was 3.31, while it was 5.44 for those in the older age group. However, this does not necessarily indicate a generational change in the number of pregnancies, because not all women in the younger age group have completed childbearing, whereas those in the older age group have.

The majority of women (42 out of 66, or two-thirds) received *some* support or help during their pregnancies in carrying out household tasks, *but not for heavy work* such as fetching water and fuel. This was equally true for both the younger and older age groups. More than half the women worked in farms as agricultural workers late into their pregnancy. *'I worked in the fields till evening, and delivered the baby at home the same night'* was a not uncommon assertion. However, only about a third of the younger women reported working in the fields during their pregnancy, as opposed to three-fourths of the older women.

Forty-one (62 per cent) of the women said that their husbands had been supportive, accompanying them to the health facility, providing financial support for care-seeking and sometimes even helping with some of the daily chores 'whenever' they were at home. The husbands included in the study corroborated this, saying that they had been happy to learn about their wives' pregnancy and had supported them. Most of them were in nuclear family situations, where no other source of help was available, and they felt that it was their responsibility to pitch in when they could.

In some instances (13 out of 66), men who had been supportive during earlier pregnancies were annoyed and even irritated with the later ones. Two women (one has already been cited above) talked about being beaten by their husbands because of repeated female births and of being neglected throughout the pregnancy. In 12 cases, the men just ignored the pregnancy and carried on as if it was none of their business.

Care-seeking during pregnancy and delivery

The vast majority of women had antenatal care for all their pregnancies: 49 women out of 66. Only three women did not have antenatal care for any pregnancy, and 14 women had antenatal care for some of their pregnancies. Two of the three women who did not have antenatal care for all their pregnancies were from the older age group. In the younger age group, there was only one woman who did not have antenatal care for her last pregnancy, which she said was unwanted. Thus, there has been a major shift in care-seeking during pregnancy. Women have begun seeking antenatal care not only from the village health nurses (VHN) who run antenatal clinics in the community once or twice a month, but also from the primary health centre (PHC). Many even go to the Medical College Hospital in Chengalpattu for 'testing' their pregnancy, for immunisation and for 'scans' in cases of complications.

Seventeen women (26 per cent) had delivered all their children in a health facility, predominantly the medical college hospital, and some in the government's block-level hospitals. Twenty-four (36 per cent) had delivered only some children—usually the first and the last—in the hospital, where they also got themselves sterilised after the last delivery. The remaining 25 women (38 per cent) had delivered all their children at home. Given that almost all women had antenatal care, the decision to have home deliveries appears to have been motivated more by economic considerations and availability of social support than lack of information. Once again, there is a distinct shift towards deliveries in health facilities among the younger age group: 38 per cent of all younger women had all their deliveries at the hospital, while only 29 per cent had all their deliveries at home.

Unless probed, most women, including those who had complicated deliveries, did not think it important to report pregnancy-related morbidity as part of their pregnancy experience. Only two out of 66 women reported pregnancy-related morbidity spontaneously. One woman reported having eclamptic fits that resulted in a premature delivery, while another reported night blindness during several pregnancies, to which no one in her household paid any attention.

However, several women experienced miscarriages,

as well as complicated deliveries resulting in early infant deaths. Eighteen out of 291 pregnancies (6.91 per cent) resulted in miscarriages and stillbirths (6). Twenty-six babies of the 219 live births (11.87 per cent) died in infancy. The most common causes reported included reaching the health facility several hours after the 'bag of waters' had burst, delivering en route to the hospital and twin pregnancies. Unexplained infant deaths within the first three days of delivery were also reported by several women.

Despite the higher level of care-seeking among younger women, natural pregnancy losses seem to be experienced more commonly by them. They lost 12.26 per cent of their pregnancies in miscarriages or stillbirths, as compared to only 5.95 per cent among the older women. Similarly, women in the younger age group experienced a much higher level of infant loss than the older age group, despite not having completed childbearing. For younger women, 13 out of 70 (18.57 per cent) live births ended in infant deaths, most of them immediately after or within the first week of birth. For the older age group, the comparable figures were 13 out of 149 (8.73 per cent).

Contraception: Knowledge and Practice

Knowledge of contraceptives

Study participants did not seem to know much about reversible methods of contraception. Only 29 of 66 women (44 per cent) knew about permanent as well as reversible methods of contraception in some detail. A further 13 knew about the permanent methods and had 'heard' about the reversible methods. Twenty-one women (32 per cent) knew only about sterilisation and vasectomy, and three women said that they did not know about any method. A slightly higher proportion of men (25 of 44 or 58 per cent) than women knew about reversible as well as permanent methods of contraception, seven (16 per cent) had only a vague idea about reversible methods but knew all about permanent methods, and 11 (25 per cent) knew only of sterilisation operations. One man said that he knew only one method for spacing births, which was induced abortion. Knowledge of reversible methods was much more common in the younger age groups—among both women and men—than in the older groups.

But reporting that they 'knew' about a particular method of contraception did not mean that they felt comfortable with it. There were several interviews where, after listing a whole range of contraceptives, respondents would later say that they did not use any reversible method because they *'did not know about any method'*. What this may indicate is that their knowledge about reversible methods is based on hearsay, but their knowledge of sterilisation operations comes from the lived experience of women for well over a generation.

Use of contraceptives

Participants' actual use of contraceptive methods did not appear to reflect their knowledge of them. In the younger age group, only two out of 32 women were currently using the 'safe period' method. It emerged from our interviews with husbands that three couples were using condoms irregularly. In the older age group, 20 out of 34 women or a little over 50 per cent of them had undergone sterilisation, while the rest were not using any method.

When examining 'ever'-use of contraception, however, a different picture emerges. Overall, only 20 out of 66 women have never used a method of contraception. Twenty-six women (40 per cent) had used a modern reversible method at some time in their reproductive lives, and 19 had used natural methods, such as safe period, coitus interruptus and periodic abstinence for spacing. Ever-use of modern reversible methods was much higher in the younger age group, with 17 out of 32 or a little over 50 per cent having used some method—mostly condoms (15), oral pills (4), and IUDs (2). Five reported having used more than one method at different times in their lives. In comparison, only nine of the 34 older women (26.5 per cent) had ever used a modern reversible method.

Reasons for not using any method of contraception

Among the older couples, lack of knowledge about any method except sterilisation is an important reason for non-use of any spacing method. While about half the women had got themselves sterilised after completing childbearing, the other half had not done so. The reasons given for this included fear of the operation, the woman's poor health because of which she was refused sterilisation by the doctor, lack of help to cope with household tasks after the surgery, fear that surgery would make it difficult for the woman to work as agricultural labourer, and being denied permission by husband or

in-laws. One woman said that she had successfully avoided conception through the use of a herbal preparation that she had been taking for several years.

> I would have had the operation a long time ago, but my mother-in-law did not allow it. Recently I went to a doctor for sterilisation, but he said that I was too weak. (OWEU–3)

> We did not go in for the sterilisation operation because there was no one to help my wife after the operation. We did not have sex frequently. Now it is 13 years after the last birth, but she has not conceived. (OMNU–6)

> My wife wanted to have sterilisation after her fourth delivery. But I objected, saying we need one daughter. So we are not using any method. (OMEU–3)

There were times when the husband and the wife had different perspectives on non-use of contraception:

> We practised only abstinence. No other method was necessary. (OMNU–1)

> Can't use any spacing method with this man who always suspects my fidelity. He does not want the operation either. (OWNU–1)

Another reason why couples did not use any method of contraception despite not wanting any more children appears to be related to the belief (usually among men) that there is no risk of conception unless one has sexual intercourse every day for a week or more. Since they did not have sex frequently, they believed that there was no need to use contraception.

> Conception won't happen in a single act of sex. It will happen only if we have sex continuously for 10 days. (OMNU–5)

> If we have sex once a week, women won't get pregnant. (OMEU–1)

Reasons for not using modern reversible methods

Fear of side-effects and embarrassment about using contraceptive methods due to lack of privacy were the most commonly stated reasons for not using reversible methods like condoms, pills and Copper-T. Copper-T was especially distrusted because women and men had heard that it could cause serious problems, such as perforation of the uterus, white discharge and weight gain. Such fears were common among both younger men and women.

> We had decided to use Copper-T. But I have been told that Copper-T leads to weight gain. She is already fat, so we dropped the idea. (YMEU–9)

> If we use Copper-T, it will go into the stomach, damage the intestine and cause white discharge. (YWEU–1)

> My cousin's wife had Copper-T inserted after her delivery, but she did not know. After some months she had severe lower abdominal pain and excessive white discharge. When she went to a doctor, she found the Copper-T and removed it. Now she is all right. (YWEU–3)

Many preferred to have all the children they wanted and then go in for sterilisation because, according to them, reversible methods were only appropriate for urban and upper-class women who did not have to perform hard manual labour.

> We haven't used any contraceptives. Even if we get it free, we won't use them because modern contraceptives (meaning spacing methods) lead to various health problems. Specifically, women's health is affected and we have to spend money for that. So, I think contraceptive operation is better. After having the next child I will undergo the operation. (YWNU–2)

> Temporary contraceptives are not suitable for us because we do hard manual work. We have to work in the field all round the year, and there is no rest. So these methods lead to various problems. I think after getting two or three children it is better to go for sterilisation. (YWEU –3)

There was also a belief that if a woman has a long interval between her first two pregnancies, the same interval would continue for later pregnancies, and that no specific method needed to be used.

> I know that I will not conceive soon. That is why I haven't used any method. Those who get pregnant frequently need to use these modern (meaning reversible) methods. (YWNU–8)

As for condom use by men, many non-users stated that they did not want to use it because it would inter-

fere with sexual satisfaction. There were also situations where men felt embarrassed to use it because of lack of privacy, and others where the men wanted to use a condom but their wives were opposed to it.

> I will use Nirodh (condom) but I am worried that if someone comes to know about it, they will mistake me (thinking I have sex with other women). This is a matter of my prestige. (YMEU–2)

> Some years back, my husband got some condoms from RUWSEC camp. I fought with him saying, 'Did you bring it so that you can have relations with other women?' (OWEU–16)

> I had decided to use condom. But she shouts at me, saying you are using condom to prevent infection that you get from other women. If I use it, I have to use without her knowledge. (YMEU–8)

Irregular use of reversible methods

A significant number of couples, especially in the younger age group, had used at least one reversible method of contraception at some point in the past, although a very small number of them were current users. The numerous barriers to effective use of reversible methods included side-effects, lack of privacy, irregular availability of free supplies and the cost incurred when purchasing contraceptives from the pharmacists.

> We used oral pills and injections to prevent conception after my second child. But my wife didn't use the pills regularly. She was breastfeeding the baby and was afraid that it might affect the infant's health. (YMEU–1)

> I use condoms if they are available free of cost. Sometimes I purchase them from medical stores. (YMNU–3)

> I had used Copper-T for one-and-half-years to space between the births. But we removed it because I became weak and had white discharge and nausea. I will go in for the operation after having the next child. (YWNU–11)

> I used oral pills for six months to avoid pregnancy. I developed nausea and giddiness. So I stopped it. (OWEU–4)

> She took tablets to space between first and second births. We got them from Chengalpattu Medical College Hospital. She had developed vomiting sensation and poor appetite, and so she stopped it. I use a condom whenever I have it. But I feel dissatisfaction in sex while using it. Also, I have teenage children so I find it difficult to use the condom regularly. (YMEU–5)

Views on Abortion

A majority of never- and ever-users of abortion in the study felt that abortion is wrong and has many negative health consequences like excessive bleeding, severe backache and abdominal pain, uterus damage, and, in extreme cases, death. Many had known women who had died from septic abortions. But they also felt that with qualified doctors performing them, abortions had become safer and more accessible in recent times. Some women who had undergone an abortion thought that it is better to have an abortion than an unwanted child. Similarly, abortion users did not think that abortion is a sin. Interestingly, many men whose wives had had an abortion felt that abortion is a sin.

> Abortion is wrong and it is equal to murder. It has wider health consequences. I know that a woman has died of it. I have also heard that women develop severe stomachaches and acidity after the abortion. (YMEU–5)

Another young man said that abortion has both negative and positive outcomes.

> Abortion is good for some and bad for others. It may lead to death if not done properly. Sometimes, if the woman does not have an abortion, it affects her young infant. (YMEU–3)

A woman who has had an abortion said:

> Considering the risks of bearing and rearing an unwanted child, abortion is good. (YWEU–5)

A woman who has four children and has experienced one induced abortion said:

> Earlier, I used to think that abortion is a sin. But now, after my own experience, I realise that it is more hazardous to women's health than any other method. So I will never take such a risk in future. (YWEU–6)

Table 2 lists the range of views about abortion expressed by men and women who have had an abortion as well as those who have never had one.

There were a few standard reasons given by almost everyone to explain why couples opted to terminate a pregnancy:

Table 2: Perceptions of Abortion among Study Participants

Perceptions	*Women**		*Men**	
	Ever-users of abortion	*Never-users of abortion*	*Ever-users of abortion*	*Never-users of abortion*
Abortion is a serious health hazard	18	22	13	14
Better to have an abortion than an unwanted birth	7	0	0	0
Abortion is a sin	2	8	6	8
Abortion is a sin but sometimes necessary	3	2	0	0
It is not wrong	4	2	0	0
There is no health problem if abortion is done under safe conditions	5	3	1	1
The choice of abortion depends on individual circumstances, e.g., economic circumstances, health situation (there can be no single view on it)	2	4	4	2
A means to have a small family	0	0	1	0

Note: * More than one view expressed.

- The earlier child was still an infant.
- Children are grown up.
- To avoid a female birth.
- Poor economic condition of household.
- Poor health of the woman.
- Astrological reasons: it is considered inauspicious to have a birth in the month of '*Chitirai*' (May, the hottest month of the year).

More than a quarter of the women (19 out of 66), including both users and non-users, said that unwanted pregnancy was caused by 'non-cooperation from husbands' who compelled women to have sex. Only 13 women held non-use of contraception as responsible for unwanted pregnancies. Clearly, the women believed that they would be able to avoid unwanted pregnancies if only men abstained from sex when a pregnancy was not immediately desired.

Experiences of abortion users

Our study included 34 women who were ever-users of abortion, with 16 belonging to the younger and 18 to the older age category. Nearly two-thirds of the women (22) had had one abortion, eight women had undergone two abortions, and two women had undergone three and four abortions respectively, making a total of 52 abortions. In four instances, the women had attempted to have an abortion in a previous or subsequent pregnancy but the method used had not been effective and they had carried the pregnancy to term. Most of the abortions (36 out of 52) had been terminated in the first trimester, and a further seven within the first 20 weeks, the legally permitted period. Thirteen women had had abortions during the sixth (10 women) and even in the seventh month (3 women) of gestation. There were no differences between the younger and older age groups in the distribution of the number of abortions per woman or the period of gestation when abortion took place.

About a third of the pregnancies terminated were of lower order—three and below—and one-fourth were of order six and above. Here we see a shift towards abortion in lower order pregnancies among younger women. Of the 18 who terminated a pregnancy of order three or below only three were older women, and of the 13 who terminated higher order pregnancies only two were younger women.

In this context, it should be pointed out that there were three cases where the number of abortions reported by the woman differed from that given by her husband, and we had to make an educated guess about who may have been reporting correctly. For example, one woman reported that she had undergone two abortions and then had a stillbirth. Her husband, who was interviewed by a different interviewer at a different time, said that for one pregnancy they had tried all possible methods for several months, and by the time they finally went to a 'proper' health facility, it was already the eighth month of pregnancy. The pregnancy was nevertheless terminated. In other words, it appears that the wife reported this late abortion as stillbirth. In another instance, the woman reported having had two abortions, whereas her husband reported four abortions. In a third case, the

woman admitted to having had an abortion but the husband called it a miscarriage. Where either spouse reported an abortion, we have counted it as such.

Decision-making on abortion

In two-thirds of the 52 abortions (34), the decision to terminate the pregnancy had been taken by the woman concerned. In a little less than half of these instances (15 out of 34), the women had not been able to get their husbands' support but had gone ahead despite the lack of spousal involvement. Instances of women going in for abortion without their husbands' explicit consent were far more common among women in the older age group (11 out of 27) than among younger women (4 out of 25).

> Already I had five sons and my husband was not cooperating with me. His second wife also had two children. Taking all this into account, I decided to abort and informed him of my decision. But he didn't agree. Then I went to my mother's home and had the abortion. My parents paid for all the expenses. (OWEU–14)

> When I told him about the pregnancy he didn't say anything. So I decided to abort it. Family members didn't know anything about it. (OWEU–6)

In 11 cases the decision was a joint one. The support of mothers/mothers-in-law was also often sought:

> I first thought of terminating the pregnancy and told him. Initially he rejected my suggestion, but I convinced him later. Finally we both decided. My mother also agreed. (YWEU–8)

Two women had undergone late abortions (seventh month of gestation) under medical advice. Five women had been compelled by their husbands and/or in-laws to have an abortion, in some cases because it was believed that the particular pregnancy was inauspicious, and in some because the pregnancy came at an inconvenient time when the family could not afford to have the woman 'confined'. These reasons for abortion are discussed in the next section.

> I was not interested in terminating the pregnancy. My in-laws and husband compelled me. When I objected, they scolded me and tried to send me to my natal home. Then I decided to go in for an abortion. (YWEU–2)

> She felt very bad and upset about aborting the pregnancy. She wept a lot. . . . I decided she should abort the pregnancy and she didn't agree. Then I explained the family situation. It took some days to convince her. (YMEU–1)

> When I told him about the pregnancy, he was silent for some time. Then he asked me to go to my mother's home and abort the pregnancy. (OWEU–1)

> My abortions—I had two—were for economic reasons. When I told him of my pregnancy he said, 'You have become pregnant in the high season for business, what can we do?' We run a shop and both of us have to work. So he decided that we should terminate the pregnancy because I would not be able to stand all day in the shop during my pregnancy and that would affect the sales and our income. He asked me to do and I did it. (OWEU–18)

Reasons given by women for having an abortion

There were a range of reasons given by women for terminating their pregnancies, although the most common ones, predictably, were to limit the family, either because they had achieved the desired family size or for economic reasons, and to have a longer interval between births.

The most common reason for abortion among women in the older age group was 'to limit family size' (11 abortions). A concomitant reason was that their children were teenagers or adults and it embarrassed them to continue with the pregnancy. A few said that they wanted to limit the family size because they could not afford any more children.

> We terminated my fifth pregnancy to limit the family size. My previous born child was already 18 years old. So I didn't want to continue with the pregnancy. He suggested that I deliver the baby and have the operation. But keeping in mind my 'mature' (attained menarche) daughters, I didn't want to continue with the pregnancy. (OWEU–13)

> My last child was 10 years old and I had an adult daughter. In this situation how could I walk around with a big belly? (OWEU–2)

> I conceived 10 times and aborted four pregnancies, mainly to limit my family. I was the only earning member in my household and I could not afford more children. (OWEU–15)

In contrast, the most common reason given by younger women was 'economic circumstances' and 'poverty' (nine abortions). A concomitant reason given by some of these women was that there was no one to support them either during or after the pregnancy.

> I aborted three pregnancies, my third, fourth and fifth ones. My family's economic situation was very bad at that time, and I was also not keeping well. He knew about the pregnancy and didn't say anything. But I decided. Only I knew the pain and the worries. (YWEU–5)

> I aborted my first pregnancy because of my family's economic crisis. We were a nuclear family and very poor. We took the decision with a heavy heart. There was no way we could manage to have this child because we had no money and no family support. (YWEU–18)

> During my second pregnancy, the elders with whom we were living decided that we should set up home separately. We were in a dilemma. Our first-born was a daughter and we were hoping that the second would be a son. He convinced me saying that we could not manage in a nuclear family without anyone to help me and with only one person working. (YWEU–17)

Another important reason given, especially by the older age group (nine out of 12 abortions), was that the previous child was too young. Women often said, '*To save the baby in hand, I decided to let go of the baby in the womb.*' But this was usually said when the previous child was a male infant. There was a fear that the pregnancy could jeopardise the health and survival of the male child—hinting at the existence of son preference even in a '*dalit*' community, which traditionally does not suffer from it because among them, women and men are equally wage earners.

However, there were only a few instances (two) when abortion was used to avoid a female birth. Both women had had several previous pregnancies that had resulted in female children, and they did not want to risk having one more daughter. The woman who reported being beaten with shoes by her husband for delivering a third female child, for example, aborted the next pregnancy. In one tragic case, the woman aborted her fifth pregnancy after three daughters in a row:

> When I was leaving for the hospital he said, 'It could be a male, don't abort it.' Even in the hospital the nurse tried to make me change my mind, but I was stubborn. When I regained consciousness after the abortion, they told me it was a male foetus. I felt devastated, like I was going mad. I wept a lot and it took me several months to feel normal. I lied to my husband and told him it was a female foetus. I never had a male child, even the next one was female and after that I had some problems and my uterus was removed. (OWEU–4)

Two women had undergone late abortions (seventh month of gestation) under medical advice. In one instance, a scan revealed that the foetus was seriously deformed and termination was advised. This was a first and wanted pregnancy. In the other instance, the foetus had to be removed because it had been damaged when the woman met with an accident. Both were younger women.

In two cases, the pregnancy was terminated because the unborn child was thought to be inauspicious.

> When I became pregnant for the second time, my husband met with an accident and injured his leg. He consulted an astrologer to predict the future and to know the reason for his accident. The astrologer said that the reason may be that the (unborn) child was inauspicious and suggested that we terminate the pregnancy. My in-laws and husband compelled me. They shouted at me, saying, 'Is your unknown baby's life worth more than your husband's?' (YWEU–2)

> In our family, it is believed that the third-born child does not survive. So they compelled me to terminate my pregnancy. (YWEU–4)

Sometimes, women gave reasons that defy all logic. For instance, a woman who had had two previous C-sections had been advised to avoid getting pregnant for the next few years. She did get pregnant, but the couple terminated four consecutive pregnancies 'for health reasons', because they felt that she would die if she continued with the pregnancies.

Who accompanied the women to the abortion service provider?

In 30 out of 52 abortions the husbands accompanied the women, and in five of them mothers or mothers-in-law also went along. Younger women were accompanied by their husbands and mothers/mothers-in-law in 21 of 25 abortions, and by their mother for two abortions. Only one woman went with a neighbour and one

had no one to accompany her. In contrast, older women were accompanied by their husbands and mothers-in-law in only 9 out of 27 abortions. They had to seek help from their mothers, neighbours, sisters-in-law and sisters, the local *dai* or distant relatives. For three abortions, older women had gone alone. This suggests that husbands among younger couples are far more involved with decisions relating to abortion and, as we have seen, these may include instances where the women are not particularly happy to terminate the pregnancy.

Choice of abortion provider

Forty out of the 52 abortions (77 per cent) were performed by rural medical practitioners, who had no formal medical training or qualifications but had set themselves up as abortion providers. It is interesting to note that most of these practitioners (there were six mentioned repeatedly) were men, contrary to the popularly held view that rural women prefer to seek services from women doctors. According to the women, some of the practitioners were assisted by their wives.

Only seven abortions were performed in government health facilities, despite the fact many of the survey villages are well connected by buses to Chengalpattu Medical College hospital and some PHCs that provide abortion services. This may have been due to the fact that having an abortion in a government facility is a time-consuming process, which few women seeking abortions can afford:

> I told him about my decision to terminate my fourth pregnancy. He just nodded his head and went away, the good-for-nothing man. I took my child, who was just a year-and-a-half, and walked from my village to the government hospital which is 4 km away. I went back and forth four to five times, but they kept asking me to come later. I would go and wait for hours and return home, then go again on the next date they gave me. Finally, I went to the private (untrained) doctor, paying Rs 100 per month of gestation. I took a relative's daughter with me to mind my baby, and gave the excuse that the baby was not well. (OWEU–7)

Only one abortion was performed by an obstetric gynaecologist, although there were two or more of them (albeit unlicensed) available in the towns where the unqualified practitioners were located. However, the use of traditional abortion providers is not common. Only two older women, accounting for four out of 52 abortions, had gone to traditional providers.

The most common method used for pregnancy termination was dilation and curettage (D&C). However, nine women reported having been given 'injections' that required them to make two visits, after which they had had the abortion at home. It is not clear whether RU-486 is being used by some local practitioners, and if so, what the source of the drug is. We could not get any details from the women on this. The method used by the traditional provider was to insert the stick of a particular tree (*erukkam kutchi*) into the cervix and induce the abortion.

Quality of care and abortion-related morbidity

Not many women commented on the quality of abortion services, except in instances when things had gone wrong. While talking to us, women often mixed up issues relating to quality of care with abortion-related morbidity. Morbidity was reported by 21 out of 34 women, with the younger and older age groups almost equally represented (11 and 10 respectively).

Excessive bleeding was the most commonly mentioned problem, reported by 17 of the 21 women. The other problems were lower abdominal pain and backache, and two women mentioned wheezing and stomach burn consequent to abortion.

> The doctor gave me an injection for becoming unconscious. But it didn't work. Then he cleaned the uterus with an instrument. The pain was killing, and I could not get up for nearly three hours after the abortion. For the second abortion I went to another hospital because I was afraid to go back to the earlier one. This time also the medicine to lose consciousness didn't work. I was conscious and felt the pain when the abortion was being done. It was unbearable. I cursed myself for being born a woman. I cursed God. I was bed-ridden and bled for 20 days. I thought I would die. In the end I had to be hospitalised. (YWEU–6)

> [After the abortion of the sixth pregnancy] I had bleeding for a long time and it didn't get normal. Then we went to the government hospital. They refused to treat me, and told me to go to the same doctor who had performed the abortion. After five months of bleeding every day, we went to a private hospital. The doctor found that there were some remaining pieces in my

uterus. I was in the hospital for seven days. I still have several problems and am often under treatment. (OWEU–3)

Initially the doctor refused to do the abortion. He said the pregnancy was above the third month. Then I begged and he agreed. He gave an injection and asked me to come the next day, when he 'cleaned' my uterus. I became quite serious [she said she had fits]. Then I conceived and delivered the next child. I wanted to have the operation, but the doctor said I was too weak and refused. This led to my fifth pregnancy. I approached the same doctor who had done the earlier abortion. He refused, saying if something happened he would be in trouble because of the problems I had the last time. I pacified him and assured him that no one would come with a complaint even if something happened to me. . . . I was very weak for many months after that. (YWEU–5)

My abortion was done in a government hospital in Madras. After I went home, I experienced bleeding for two weeks but didn't think much of it. Then suddenly there was uncontrolled bleeding. I had to fold an entire sari and use it as a pad while I went by bus to the hospital. The entire sari was soaked, even my seat on the bus was getting soiled. I returned from death's door after several days in the hospital. (OWEU–9)

Abortion Use and Gender Power Relations within Marriage

In this section, we attempt to examine whether there are differences between ever-users and never-users of abortion in significant aspects of gender power relations within marriage. We have used the following indicators to compare the two groups:

- Whether the marriage was with the consent of both (more equal power relations) as against the woman being forced into the marriage (unequal).
- Whether the women reported unhappiness and dissatisfaction with the marriage (unequal).
- Women's role in decision-making within marriage: joint (more equal), some decisions (less equal), no decisions (unequal).
- Women's freedom of movement and freedom to act independently.
- Absence of non-consensual sex, sexual violence and any other intimate partner violence.
- Husbands' cooperation in pregnancy prevention.

We then discuss abortion users' own perception of the role gender power relations play in their exposure to the risk of unwanted pregnancy. We follow this with an analysis of other possible factors that may contribute to making women abortion users/non-users.

Type of marriage and satisfaction in marriage

Overall, there do not seem to be any major differences between abortion users and non-users, either in terms of consent to marriage or in terms of satisfaction with marriage. However, the number of love marriages is higher among younger than among older couples.

Role in decision-making

A noticeable difference between abortion users and non-users in terms of women's role in decision-making can be seen in the numbers who reported a traditional

Table 3: Satisfaction in Marriage

	Ever-Users of Abortion Couples		*Never-Users of Abortion Couples*	
	Younger	*Older*	*Younger*	*Older*
Arranged marriage with consent	7	8	5	6
Arranged marriage, forced	2	3	3	2
Love marriage	3	0	3	2
Total	*12*	*11*	*11*	*10*
Both satisfied	8	7	7	8
Wife not satisfied	3	4	3	2
Husband not satisfied	0	0	0	1
Both not satisfied	1	0	1	0
Total	*12*	*11*	*11*	*10*

Table 4: Status of Couples in Household Decision-making

	Ever-Users of Abortion Couples		*Never-Users of Abortion Couples*	
	Younger	*Older*	*Younger*	*Older*
Both say that decisions are jointly made	1	1	2	1
Both say: 'Men decide money matters and women decide household matters	6	4	3	2
Both say that the man makes all decisions	3	2	2	4
Discordance: Wife says husband is decision-maker, husband says joint decision	2	3	3	3
Decisions made by in-laws, neither the husband nor the wife has much of a say	0	0	1	0
Total	*12*	*11*	*11*	*10*
Need husband's permission to go anywhere	11 of 16 women	11 of 18 women	10 of 16 women	5 of 16 women
Need husband's permission to go to natal home	11 of 16 women	11 of 18 women	9 of 16 women	6 of 16 women

division of decision-making authority—with men deciding on all money matters and women deciding on household matters—and those who did not. Ten out of 23 in the abortion users group reported a traditional division, as compared to only 5 out of 21 in the non-users group. On the other hand, the number of couples where men make *all* decisions is approximately the same for both groups. It is important to point out in this context that we could discern no clear or definite differences in decision-making roles, except that more women in the abortion users group reported the stereotypical, traditional division of men taking decisions on money matters and women on household matters such as buying vegetables and groceries for daily use and perhaps some small extras, like flowers, for the woman herself.

We therefore thought it would be worthwhile to examine other aspects of women's autonomy, such as freedom of movement. In Table 4 we have included this in the category 'needing permission'. It is important to point out here that the vast majority of women who fell into this category had to get the husband's permission every time they wanted to go somewhere. But the matter does not end with that. Not only were they not allowed to go anywhere without permission, they were also not allowed to go anywhere without an escort, except perhaps to the health facility if the children were suffering from health problems. Visiting the natal home seems to be a particularly sensitive issue. Several women, especially in the younger age group, reported that they were permitted to visit their parents only if accompanied by their husbands. They also said that they were not allowed to go to their natal homes very frequently, nor were they allowed to spend the night there. Regular contact with the natal home is viewed by women as something that empowers them, whereas men view it as a threat to their authority.

In addition, there is a difference in the degree of freedom enjoyed by abortion users and non-users, both among younger and older women. Most of the older women in the never-user group reported that they had greater freedom of movement now than in the past. Among them, the amount of freedom they enjoyed clearly increased with age. But this pattern did not seem to hold in the ever-user group. It is therefore safe to suggest that there are differences in the autonomy and freedom enjoyed by women who experience an abortion and those who don't. This hypothesis gains further ground when we examine the next set of indicators related to non-consensual sex and sexual violence.

Non-consensual sex, sexual and other forms of violence

Overall, violence is more common in the abortion users' group. However, non-sexual violence is more common in the non-users group. The important difference between abortion users and non-users appears to lie in

Table 5: Sexual and Other Forms of Violence against Women

	*Ever-Users of Abortion Couples**		*Never-Users of Abortion Couples**	
	Younger	*Older*	*Younger*	*Older*
Non-sexual violence	12	10	9	7
Non-consensual sex	8	10	7	5
Sexual violence	9	8	7	3
Total	*12*	*11*	*11*	*10*

Note: * Some women suffered more than one form of violence.

non-consensual sex and sexual violence, which is far more common among the former than the latter. By allowing women little control over their sexuality, non-consensual sex and sexual violence expose them to the risk of unwanted pregnancy. Many of the women considered unwanted pregnancy and abortion to be a direct consequence of non-consensual sex, often accompanied by violence when the women resist.

> I could have avoided my abortions but he didn't cooperate with me [did not accept her refusal to have sex]. (OWEU–18)

Some women reported that their husbands compel them to have sex by saying that in case they got pregnant, they would pay for the abortion.

> If I reject his desire to have sex, he says, 'It is me who will be meeting the expenses. If you conceive you can go for an abortion.' But he doesn't realise the problems associated with abortions. (YWEU–17)

We heard numerous stories of women's unsuccessful attempts to avoid pregnancies, which had ended in unwanted pregnancies, abortions and, sometimes, even unwanted births. The men, on the other hand, tended to blame the wife for getting pregnant frequently: *'You get pregnant with a single touch.'*

> When I express reluctance for sex saying that I am worried about getting pregnant, he says, 'I will take care if it happens.' If I object strongly he shouts, 'Are you sleeping with someone else?' After my first childbirth, he called me for sex within a month. When I objected, he beat me. This is a regularly happening in my life. (YWEU–2)

An older woman who, when we interviewed her, was pregnant for the fifth time, said:

> He is working outside the village and comes home once in two or three days. In that situation I am not able to say no, even if it is during the day. I have to accept it. If I object, he shouts, 'When I am not at home, who comes here?' I have to accept his desire, otherwise I have to face beating and shouting. This is something that happens to most women.
>
> If I give fear of pregnancy as a reason, he won't leave me alone. He says conception doesn't take place frequently. I am pregnant now. Everyone is talking about my getting pregnant after having grandchildren. I am ashamed. . . . I wanted to abort this pregnancy, but the doctor refused saying I was very weak. Also the pregnancy was in the sixth month, I did not realise because my periods were not regular. If I get sterilised I can live without fear. But he says, 'You are physically weak, don't do it [have sterilisation]. But I am stubborn; I have experienced two unwanted pregnancies [one was terminated] and I am ashamed of it. (OWEU–17)

A young woman of 25 years, who was also experiencing her fifth pregnancy, said:

> I have aborted two pregnancies—the second and the fourth. I was very worried. I first decided to end my life, but then I boldly decided to go in for abortions. There was no other way. He said, 'You get pregnant with a single touch.' Fear and embarrassment in asking for spacing methods and his compulsion for sex have led to three unwanted pregnancies and two abortions.
>
> Even though men are responsible for pregnancy, people generally say that it is the woman's fault. They say, 'Men are good, but women are foolish, emotional and looking for body pleasure. I felt very bad when some people teased me saying that I don't leave my husband alone for a minute and that my stomach is always bulging [because of pregnancy]. (YWEU–6)

Contraceptive Use

In these circumstances, it is relevant to ask why, if they are so keen to avoid pregnancy, do women not use any method of contraception? When we compare contraception usage among abortion users and non-users, we find that women who have had an abortion have tried to use a method of contraception at some time in their lives. This trend is corroborated by NFHS data, which shows an association between a current unwanted pregnancy and ever-use of reversible methods of contraception.

Reasons for irregular use of contraceptive methods have been discussed in an earlier section. The most commonly used form of contraception was the condom, which the men discontinued or used irregularly for reasons such as non-availability of regular supplies, interference with sexual satisfaction and costs. Reasons for discontinuing the pill and Copper-T were usually related to side-effects.

Husbands' opposition to use of any method of contraception was more common among older women, although some of the younger women also mentioned it.

> Only he is responsible for the abortion, because first he prevented me from having an operation and then he beat me when I was reluctant to have sex. So again it led to another unwanted pregnancy and abortion. (OWEU–2)

> Currently I am pregnant. I had decided to abort this also, whether I live or not. But he and my father convinced me to have this child and have the operation. [After the previous abortion] the doctors did not say anything about preventive methods [contraceptives]. When I asked him [my husband] to find out whether there is anything to avoid getting pregnant, my husband said, 'Am I having sex with a prostitute that I have to ask about preventing pregnancy?' (YWEU–6)

> He didn't want us to use any contraceptives and that is why it [the abortion] has happened in my life. (YWEU-15)

Average Number of Pregnancies and Live Births

There appeared to be interesting differences between women who have had an abortion and who have not, in the average number of pregnancies experienced, pregnancy losses and infant deaths.

The ever-users group had a higher average number of pregnancies and live births than the never-users group. When viewed in conjunction with the higher reporting of sexual violence and non-consensual sex among ever-users of abortion, we can see that the factor that distinguishes women who have abortions from women who do not is the exposure to repeated, unwanted pregnancies because of non-consensual sex.

Table 6: Contraceptive Use among Women

	Ever Users of Abortion		*Never Users of Abortion*	
	Young	*Old*	*Young*	*Old*
Ever used one or more modern reversible methods	11	8	6	1
Ever used one or more natural methods (safe period, abstinence, coitus interruptus)	4	7	3	5
Ever used sterilisation	0	9	0	11
Never used any method of contraception	4	4	8	4
Total	*16*	*18*	*16*	

Table 7: Pregnancy Outcome and Infant Deaths

	Ever-Users of Abortion Women		*Never-Users of Abortion Women*	
	Younger	*Older*	*Younger*	*Older*
Average number of pregnancies	4.06	6.28	2.56	4.50
Average number of live births	2.56	4.61	1.81	4.13

CONCLUSIONS

We started out by asking whether and how gender power relations affect the choice of abortion to space or limit births, and whether these have changed across generations. We also wanted to examine the differences between the group of never-users and ever-users of abortion in terms of how gender power relations played out within marriage.

We find that overall, women have limited decision-making powers within the household, even in the younger age group. Men control most of the decisions. Women may have physical mobility, but only for specifically sanctioned purposes, such as taking the child to a health facility or to go to the market. Women also cannot participate in any public activities without their husbands' prior permission. In this respect, there is not much difference between women in the younger and older age groups. If older women appear to have more autonomy, it is very likely because, as they grow older, they are viewed less and less as 'sexual beings'. Thus, if freedom is a variable associated with age, then we can only compare the two groups if we take into account what the older women experienced when they were young. When we tried to probe this issue, some of the older women did say that they were much more restricted when they were young, and that the current younger generation seems to enjoy more autonomy.

Discussion and communication on sexual matters are rare, but when they do happen, it is among the younger couples. On the other hand, non-consensual sex and sexual violence are also more common in the younger than in the older age group.

Non-consensual sex and sexual violence appear to underlie the need for abortions among many couples, both young and old. Although women are well aware of their sexual rights and believe that men ought to take the responsibility for preventing a pregnancy, the reality they have to contend with is very different. Women go through one pregnancy after another—terminating them when they can, and carrying them to term when they cannot.

There are many differences between younger and older couples who have used abortion. Older women often have to make the decision by themselves; many have little support from their husbands and have to take the help of their mothers, sisters and neighbours. They also have to seek abortion from places that are affordable, including traditional abortion providers. Among younger couples, the decision to abort is supported by the husband, who accompanies the wife to the abortion facility and pays for the services. This is despite the fact that the pregnancy might well have been the consequence of sexual coercion on his part. Some women's reports indicate that men may be taking abortion very lightly—as something they can pay for and be done with. The frequent mention of poverty and economic considerations as a reason for abortion in the younger age group, and also instances of younger women being compelled to terminate their pregnancies, are rather disconcerting developments.

What are the differences between never-users and ever-users of abortion, especially in terms of gender power relations within marriage? Our data on contraceptive use suggest that non-users of abortion are as exposed to the risk of unwanted pregnancy as abortion users, or perhaps more so, other things being equal. One feature that distinguishes the two groups is that among the 'never-users', more husbands 'cooperate' in preventing unwanted pregnancies, taking responsibility for fertility control even though they do not use condoms. This explains the lower average of pregnancies experienced by the 'never-users' group, and also its lower reporting of non-consensual sex and sexual violence.

In the abortion users group, while some initiative is taken by men to use condoms, the use is inconsistent and irregular. Women are unable to use the pill and Copper-T because of side-effects. Many women are also hesitant to use any form of contraception without their husbands' explicit approval, because they fear that in the event of side-effects, the men may not pay for their health care. When efforts to prevent pregnancy through contraceptive use fail, and men are unwilling to abstain from sex, women have to rely on abortions to prevent unwanted births. They do this at considerable risk to their health.

The most noticeable distinction between 'ever-users' and 'never-users' of abortion is the preponderance of non-consensual sex and sexual violence among the former. Thus, most unwanted pregnancies are usually the consequence of unwanted sex and women's inability to refuse their husbands' sexual demands. Many men seem to believe that sex within marriage is their right, and that women have no say in the matter.

Interventions to prevent unwanted pregnancies would have to address the issue of sexual violence within marriage, as well as intensify efforts to make reversible contraceptives acceptable and available free of cost

regularly to young couples. RUWSEC has held sexuality and reproductive health education workshops for newly married couples in the past. These workshops were welcomed by the young men and women not only as an opportunity to learn about sexuality and reproduction, but as a forum to clarify and understand better women's and men's differing perspectives on these matters. It seems important to continue with these workshops on a regular basis and, within them, to address abortion as an issue of non-consensual sex.

RUWSEC's work on promoting reversible contraceptives has been largely focused on distribution of condoms and, to some extent, oral pills. Condoms have been distributed through community-based volunteers, but pills have been procured and distributed only on request. We have tended to err on the side of caution when promoting contraceptives, mainly because of the legacy of population control in our state, which has made people suspicious of anyone promoting contraception. Remarks by respondents in the study make it clear that a more proactive approach on the part of the RUWSEC volunteers would be welcomed by both women and men, who feel embarrassed to approach the volunteers or nurses to ask for contraceptives.

A campaign addressing the unacceptability of sexual coercion within marriage would be another important intervention that we need to implement. It is our hope that in the years to come we will be able to change attitudes and behaviour among the younger generation.

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APPENDIX A

The Project's Ethics Committee	
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APPENDIX B

Table 8: Fertility Differentials in Tamil Nadu, 1998–99

Characteristics		*TFR*
Residence	Rural	2.23
	Urban	2.11
Caste	Scheduled caste	2.25
	Scheduled tribe	2.39*
	Other backward castes	2.18
	Other castes	1.69
Education	Illiterate	2.49
	Literate, < middle school complete	2.37
	Middle school complete	2.21
	High school and above	1.85
Standard of living index	Low	2.39
	Medium	2.10
	High	1.93

Source: National Family Health Survey-II, National Report, 1998–99, Mumbai: IIPS.

Table 9: Percentage Growth in State Domestic Product between 1981 and 1993–94 and Percentage of Population below Poverty Line in 1993–94

States	*% Growth in SDP (1981 to 1993–94)*	*% of Population Living below Poverty Line 1993–94*
Andhra Pradesh	21.02	22.19
Assam	51.05	40.86
Bihar	20.26	54.96
Gujarat	16.91	24.21
Haryana	43.82	25.05
Himachal Pradesh	24.62	28.44
Karnataka	51.08	33.16
Kerala	37.39	25.43
Madhya Pradesh	27.30	42.52
Maharashtra	59.09	36.86
Orissa	24.74	48.56
Punjab	43.90	11.77
Rajasthan	39.57	27.41
Tamil Nadu	54.98	35.03
Uttar Pradesh	23.56	40.85
West Bengal	31.21	35.66

Sources: Estimates of state domestic products: Directorate of Economics and Statistics, New Delhi: Government of India, various years. Population below poverty line: estimates from Planning Commission, Modified Expert Group, New Delhi: Government of India, 1993–94.

Table 10: Pregnancy Outcome Pattern and Estimated Abortions in India and Its Major States, 1992–93

States	*Still Births*	*Live Births*	*Estimated Abortions per 1000 Births*
Andhra Pradesh	2.9	92.3	36.4
Assam	2.8	89.6	84.3
Bihar	2.4	93.4	45.0
Gujarat	1.2	93.1	62.3
Haryana	2.6	89.5	89.4
Karnataka	2.0	92.0	65.2
Kerala	1.6	90.4	88.5
Madhya Pradesh	1.7	94.5	39.2
Maharashtra	2.0	92.9	55.0
Orissa	2.7	92.8	48.5
Punjab	3.2	92.0	52.2
Rajasthan	2.6	93.1	NA
Tamil Nadu	2.7	86.0	131.4
Uttar Pradesh	2.1	92.0	64.1
West Bengal	2.3	92.5	56.2
India	-	-	63.0

Source: Columns 1 and 2 are from various state reports of NFHS-I. Abortion rates include both spontaneous and induced abortion, and are estimates from Irudaya Rajan, Mishra and Vimala (1997).

Table 11: Master Grid Used for Analysis of Qualitative Information from Individual Interviews

Category of Respondents: (Young/Older, Women/Men, Never-User/Ever-User of Induced Abortion)								
ID no.	Background Characteristics of Interviewee	Background Characteristics of Spouse	Decision-making: Marriage and Dowry	Decision-making: Household Matters	Sexual Relations and Decision-making	Pregnancy and Childbirth	Contraception and Perspectives on Abortion	Abortion Decision-making and Abortion Experience (for Users of Abortion)

Table 12: Master Grid for Analysis of Qualitative Information Pertaining to Couples

Category of Respondents: (Young/Older, Women/Men, Never-User/Ever-User of Induced Abortion)								
ID no.	Background Characteristics of Interviewee	Background Characteristics of Spouse	Decision-making: Marriage and Dowry	Decision-making: Household Matters	Sexual Relations and Decision-making	Pregnancy and Childbirth	Contraception and Perspectives on Abortion	Abortion Decision-making and Abortion Experience (for Users of Abortion)
Wife 1								
Husband 1								

Socio-Economic and Medical Correlates of Pregnancy Wastage among the Poor

A Case Study of a Village in Coastal Karnataka

K. SUSHEELA
K. NAGARAJ

INTRODUCTION

This study was undertaken with two main objectives. One was to broadly estimate the extent and components of pregnancy wastage amongst two poor occupational groups, i.e. agricultural labourers and beedi workers, in Udipi district, a relatively advanced region in coastal Karnataka. The second was to understand the social, economic and cultural, as well as medical underpinnings of the issue in these two groups.

Pregnancy wastage, while an important issue in reproductive health, is equally a social issue that is moulded by socio-economic and cultural features. In other words, pregnancy wastage in the study region is closely impacted by certain socio-economic and cultural elements that are *specific* to the region. Identifying and exploring these elements and examining the manner in which they influence pregnancy wastage thus formed the major thrust of the study. This perspective also has an important corollary in relation to abortion rights. The right to abortion—in the sense of free and informed choice—has to be viewed as part of a larger constellation of rights, of which reproductive rights is an important element. The right to abortion cannot be viewed in isolation from the context in which it operates, or the power relations that characterise that context. Even in a relatively liberal milieu—which, for historical reasons, our study area represents—recourse to induced abortion often is *not* a free choice.

Some details on the socio-economic and cultural elements that have a bearing on pregnancy wastage are provided in the following section. How these elements were brought on board in the study is dealt with in the next section, which also outlines the method adopted by the study and provides some basic information on the sample respondents. In the third section, various quantitative estimates of pregnancy wastage and its components are dealt with, as well as their variation across various social groups. The remaining two sections deal with specific components of pregnancy wastage: the fourth, in some detail, with induced abortion, and the last, very briefly, with spontaneous abortion.

STUDY REGION: UDIPI DISTRICT

Locational Details

Udipi district, which was created as a separate district in 1998 by bifurcating the erstwhile composite district of Dakshina Kannada (known earlier as South Kanara), is one of three coastal districts in Karnataka today, with North Kanara to its north and the present Dakshina Kannada district to its south. It is a narrow strip of land running south to north, wedged between the Arabian Sea on its west and the Western Ghats on its east. While in overall terms the area presents the picture of a

developed region, it is characterised by a high degree of imbalance and inequity in spatial, sectoral and social terms.

The coastal part of the region—which is just about a village 'thick' to the west of a national highway that runs south to north—is relatively more advanced compared to the interior parts, or the ghat region, in the eastern part of the district. The survey village is in the interior and hence belongs to the more backward part of the district.

Different Sectors of the Economy

The primary sector of the district's economy is characterised by a duality wherein, while high-value cash crops (like cashew and coconut), forest produce and fisheries make a large contribution to the income from this sector, cultivation of the major foodgrain, i.e. paddy—which continues to be the major source of livelihood for a very large section of the population—is carried out with a low level of technology. This is largely due to the fact that while the region receives abundant and assured rainfall from the southwest monsoon, the topography of the region renders any control of water difficult. This absence of agricultural modernisation has resulted in a high level of unemployment and underemployment in the region, forcing the poor to adopt alternative survival strategies like migration—permanent or seasonal—and non-agricultural activities, the most important of which is beedi-rolling. The study was confined to two of these poor occupational groups in the survey village: agricultural labourers and beedi workers.

The most striking feature of the district's economy is its highly developed tertiary sector, particularly along the coastal belt. Apart from enjoying a very high banking density, the region's trade and transportation facilities are also highly developed. As a consequence, there is a definite pattern of urbanisation obtaining here which, although not high, is continuous and widespread. The towns in the region have not developed in isolation, but form part of a continuous though thin urban spread; the distinction between a rural settlement and an urban one is very weak. The large proportion of workers engaged in rural non-agricultural employment, as well as the high spatial mobility of the population, reinforces this picture.

Social Sector Development

Other striking aspect of the region is its highly developed social sector. By 1991 every village in the district had at least one school; consequently, the region has a high level of literacy (see Table 1). It has a large number of educational institutions, including many professional ones. The region also has a fairly well-developed system of health care. In fact, a recent study on district-wise human development in the country (Geetha Rani

Table 1: Some Indicators of Development of Dakshina Kannada Region

Region	Education and Health Care				Availability of Amenities					Composite Indices of Development			
	Degree of literacy 2001	Percent of villages in 1991 with			Percent of villages in 1991 with					Number of bank branches per 100,000 population in 1995	Human Development Index, 1995	Rural Infrastructure Development Index,1991	CMIE Infrastructure Development Index, 1995
		Primary school	Secondary school	Primary health care centre	Post office	Telephone connection	Bus stand	Pucca road	Electricity				
Dakshina Kannada region	82.1	100.0	33.2	15.5	88.3	81.5	93.8	87.2	100.0	17.6	0.70	93.9	120.1
Karnataka state	67.0	86.4	10.0	5.9	30.3	16.1	67.1	65.5	98.0	9.3	0.48	59.3	106.1
All -India	65.4	72.8	7.7	3.0	22.5	5.7	33.8	37.0	86.0	6.7	0.42	40.3	100.0

Note: Dakshina Kannada region refers to the erstwhile (composite) Dakshina Kannada district from which the Udipi district was carved out in 1998. The data on the above indices are not available for Udipi district as yet; but the figures for erstwhile Dakshina Kannada, given above, provide a fair representation. Even though Udipi district is relatively less developed compared to the present Dakshina Kannada district, the gap between the two is not wide and is rapidly diminishing.

Source: (1) All data for 1991 are from Census of India, 1991 and the degree of literacy for 2001 is from the census of that year.
(2) The HDI for 1995 are from Geetha Rani (1999).
(3) The CMIE Infrastructure Development Index, 1995 and bank density, 1995 are from CMIE (2000).

1999: 30) ranks the erstwhile (composite) Dakshina Kannada district, from which Udipi district was carved out in 1998, as the first in the country. However, this is the overall picture. Access to health care and education for the poor in the region—while better than in most other parts of the country—leaves much to be desired. And the trend towards privatisation has done little to address these inequalities.

In sum, there appears to be a basic disjunction, as it were, in the socio-economic situation of the study region. The nature and development of the productive sectors—agricultural in particular—and the imbalances and inequalities render large sections of the population poor and vulnerable. At the same time, the high level of infrastructure and social development, the 'mobile' character of the population and rural–urban linkages, high level of rural non-farm employment, and exposure to mass media like the television and radio lead to a situation where the transference of urban lifestyles and values to the rural population, including the poor, is quite high. As a consequence, people's aspiration levels are correspondingly high. It is this disjunction, between poor living conditions on the one hand and aspiration levels on the other, that underlies another basic phenomenon with important consequences for pregnancy wastage among the poor in the study region—i.e. rapid fertility transition.

Fertility Decline

During the last decade, the district witnessed a rapid decline in fertility rate, which today, at 1.5, is below replacement level. In fact, it is one of the lowest among all districts in the country (Guilmoto and Irudaya Rajan 2002: 665–72).[1]

While advances in the social sector—female literacy in particular—may be a factor underlying the low fertility rate in the district, we believe that they constitute only a partial explanation. Using female literacy as a proxy for social sector development, our point is made amply clear by a comparison of the district with three districts in Kerala that have the same fertility rate (1.5): in 2001, Alappuzha, Ernakulam and Pathanamthitta had female literacy rates of 91.1 per cent, 91.0 per cent and 93.7 per cent respectively, while the corresponding rate for Udipi was significantly lower, at 74.0 per cent. If social sector development was the main factor underlying fertility decline (or level), then Udipi should have had a significantly higher fertility rate compared to the districts in Kerala. The fact that its fertility rate is lower would indicate that there are factors other than social sector development operating here.

A plausible explanation for the low level of fertility may have to do with the high and increasing aspiration levels in the district. Inability to meet these aspirations leads to what we term 'aspiration gaps', particularly among the poor. And one way of bridging this gap is through family limitation—or social capillarity, as it is referred to in the literature. Fertility transition here occurs essentially through family limitation, with increase in age of marriage and spacing making very little contribution. This is precisely what has happened in the study region in the last decade: the two-child norm has been more or less accepted, even by the poor.

Issues of development in social and physical infrastructure and rapid fertility transition in the study region have been dealt with in some detail because both can have important implications for pregnancy wastage. High levels of social and physical infrastructure development can make for better access to health care facilities and hence may facilitate reduction in pregnancy wastage; on the other hand, such a situation may also make for a more liberal or permissive attitude towards induced abortion and hence an increase its incidence. Rapid fertility transition based almost solely on family limitation can also affect pregnancy wastage in a number of ways. Reduction in the total number of pregnancies can lead to reduction in pregnancy wastage and, depending on the relationship between pregnancy wastage and birth order, it can also affect the rate of pregnancy wastage. On the other hand, the emerging fertility behaviour, with its emphasis solely on family limitation and with next to no reliance on late marriages and longer spacing intervals, can lead to an increase in pregnancies-at-risk and hence to an increase in pregnancy wastage. The desire to limit family size can also increase recourse to induced abortions. Some of these linkages between socio-economic development indicators and fertility transition, on the one hand, and pregnancy wastage, on the other, will be taken up for discussion in later sections.

Female Autonomy

There is one more socio-economic and cultural dimension that needs to be dealt with in some detail, and that is the issue of female autonomy. Given its obvious consequences for decision-making by women on matters

relating to reproduction, health care and abortion, it is an issue that has important implications for pregnancy wastage.

Patriarchal values that underpin gender discrimination are a characteristic of all societies, and our study region is hardly an exception to this. But leaving it at that would be analytically counter-productive because societies do differ in terms of the degree to which such discrimination exists, the manner in which it manifests itself and the underlying factors that modulate or exacerbate such discrimination.

For a number of historical, socio-economic and cultural reasons, the extent of gender discrimination in Udipi district, as well as in the present Dakshina Kannada district, is of a significantly lower order than in most other parts of the country. Data on three broad, aggregate markers of gender discrimination, presented in Table 2, testify to this. The three markers used are: juvenile (for population age 0–6 years), which captures differential survival chances for females, and literacy and gainful employment (outside the 'kitchen') which, by broadening social horizons, would provide the necessary (although not necessarily sufficient) conditions for the empowerment of women.

The *Aliya Santhana* System

While the role of advances in the social sector—access to literacy in particular—and access to non-farm employment in modulating gender discrimination in our study region is significant and hence cannot be discounted, equally important in this respect is a factor specific to this region, viz., the matrilineal system of inheritance that is still prevalent to a significant degree. In this system, known as *Aliya Santhana*, ownership rights are with the women of the household and are inherited through the female line; the right to manage the property, however, is in the hands of the oldest male of the joint household, though it devolves not on his own but his sister's son. The system is matrilocal in the sense that after marriage the woman stays back with her children in her parental home, where the husband visits her. The oldest female of the household is considered the head of the household.

This system of inheritance was once widely prevalent and practised by the bulk of the population: the Bunts (who are the dominant landholding community); the Poojaris (whose traditional occupation is toddy-tapping); and the Mogaveeras (who are traditionally fishermen). The *dalits*, who are largely agricultural labourers, also followed the *Aliya Santhana*, but the brahmins and other minorities (Muslims and Christians) in the region did not. For a variety of reasons—economic, social and legal—this system started disappearing, particularly from the more advanced coastal belt in the region, possibly from around the early 1970s. But it is still practised in the relatively backward interior parts of the district—including our survey village—particularly by the Poojari, Mogaveera and *dalit* communities that account for a major proportion of agricultural labourers. The Muslims, most of whom are beedi workers, follow the patrilineal system. But a substantial number of beedi workers are also Poojaris and Mogaveeras, who follow the matrilineal system.

It is a moot point whether this system led to the empowerment of women even during its heyday. First of all, among the landed class—the Bunts—the right to manage land and property lay with the oldest male member and this meant he was the decision-maker for most matters relating to the running of the household and managing the property. It was only in matters relating to partition, sale and inheritance of property that women had a say. But even here, the rights vested with *all* female

Table 2: Some Indicators of Gender Discrimination in Udipi District

Region	Sex Ratio, 2001		Literacy Rate, 2001			Work Participation Rate, 1991		
	For 0–6 age group	For the whole population	Male	Female	Index for female with male - 100	Male	Female	Index for female with male - 100
Udipi district	955	1127	86.6	74.0	85	51.7	35.1	68
Karnataka state	949	964	76.3	57.5	75	54.1	29.4	54
All-India	928	933	75.9	54.2	71	51.6	22.3	43

Notes: 1. Work participation rate data for 2001 are not yet available; the 1991 data given here refer to the erstwhile (composite) Dakshina Kannada district from which Udipi district was carved out in 1998.
2. Sex ratio is number of females per 1,000 males.

Source: Census of India 1991 and 2001.

descendants in the household (or *Manethana* as it is locally known) rather than with any single female member. Secondly, this system of inheritance led to enormous concentration of land with a few very powerful landlord households and consequently resulted in extreme forms of oppression, both economic and social, of the poor peasantry (men and women).

All the same, it appears that among the poorer sections of the peasantry, i.e. the property-less, the system does provide considerable leeway and authority to women within the household: since the system is matrilocal, the woman is considered the head of the household, and remarriage—of widows as well as divorcees—is permitted. Our assessment is that this system, coupled with women's access to employment (particularly access to cash income from non-farm employment) provides women an autonomous space within the domestic sphere and an important role in some aspects of decision-making. Decisions regarding health-seeking behaviour for herself and her children is one such aspect—and this, we believe, has important implications for maternal health and hence for pregnancy wastage.

Apart from providing women with some autonomy, the system affects pregnancy wastage in two other ways. First of all, the continuation of the family lineage depends crucially on female offspring. If a woman fails to provide a child, the family can adopt one, but again, adoption for inheritance purposes is restricted to a girl child. Such a premium on female offspring has meant that both sex-selective abortion and female infanticide are practically unknown in the region. An important contributor to induced abortion in many other parts of the country is thus absent in this region.

Secondly, the rules governing the family in *Aliya Santhana* make for a reasonably liberal milieu in relation to marriage and male–female relationships. Illustrative of some of these rules—known as *Kattu-Kattalais*—are the following (Census of India 1961: 41-43):

- A girl who loses her husband is called a Budhavathi. If she becomes pregnant before remarriage, she may be given in marriage to the person by whom she became pregnant if she is of the same cast.
- If a husband goes to a foreign country leaving a married girl behind, she may be given away in marriage again after five years. If she becomes pregnant, she can be kept by the paramour if he is of a higher caste, be married to him if he is of the same caste, degraded and joined to the caste of the paramour if he is of a lower caste.
- If a married woman is found to be guilty of adultery, the husband may deliver her to the family and she may be wedded to another person. If the husband takes up with another woman and does not treat the wife properly, the family may give her in marriage to another. Similarly, if the husband ill-treats the wife by beating and abusing her, reconciliation may be effected between them three or four times; but should such behaviour recur, the family may get her married to another person.
- If a girl attains puberty and becomes pregnant before marriage, such a girl and the person who caused the pregnancy are both fined and the girl is placed in the keeping of the person if he is of a higher caste and loses caste if he is of an inferior caste.

It is doubtful that these *Kattu-Kattalais* are still followed today. In all probability they are not; but they do provide a cultural sub-stratum for the development of a liberal milieu in relation to attitudes towards marriage, man–woman relationships, and premarital and extramarital relationships. A liberal attitude towards induced abortions would be a corollary of this.

Lest we give the impression that our study region is one with little or no gender discrimination, we reiterate the caveats entered earlier: the higher degree of autonomy enjoyed by women under the *Aliya Santhana* system is purely relative—relative, that is, to most other parts of the country where women enjoy very little autonomy. Even here, as our foregoing discussion has clarified, such autonomy that women enjoy within the domestic sphere is circumscribed by power relations defined by class and caste.

Moreover, along with the waning influence of *Aliya Santhana*, there appear to be signs of a counter-tendency, one that may lead to a decline in female autonomy. The process of elite-emulation or Sanskritisation on the part of the lower castes and the poor is unmistakably visible in the region. A clear indication—or consequence—of this is the rapid replacement of the practice of bride price by dowry among communities that follow *Aliya Santhana*. The factors underlying this process and its consequences for female autonomy are far too complex for us to deal with in any detail here. Suffice it to say that strong imprints of the *Aliya Santhana* system are clearly visible in our

survey village even today, and hence need to be taken on board.

To recapitulate, our discussion so far has identified some broad, region-specific socio-economic and cultural dimensions that need to be taken into consideration while studying pregnancy wastage among two poor occupation groups: agricultural labourers and beedi workers. These dimensions are:

(a) High social sector and infrastructure development and the consequent high access to mass media, urban areas and non-farm employment;
(b) Rapid fertility transition brought about essentially through family limitation;
(c) Provision of a certain degree of autonomy to women, particularly working women, by the matrilineal system of inheritance prevalent in the region.

METHODOLOGY

Choice of Village

The village Phulwady—which is a rather thinly concealed pseudonym—was one of two villages surveyed by us in 2001 in the erstwhile (composite) Dakshina Kannada district as part of a study on beedi workers in the region. Choosing one of the two villages had certain advantages: we already had a good database for both villages, comprising a detailed house-listing with a census-type enquiry; a village-level enquiry on beedi workers; and a detailed survey of 100 beedi worker households (in each village). We had also established good rapport with the residents of both villages. Moreover, while the survey had provided some basic information on the health status of female beedi workers, it was clear to us that it needed more detailed and focused attention. In addition to collecting information on pregnancy wastage, we hoped that the present survey would serve to bridge this important gap.

We selected Phulwady for our present study because, of the two villages surveyed in 2001, this village is in the interior and therefore relatively more backward. Consequently, unlike the other village, it also has a large section of agricultural labourers and hence was ideal for a comparative study of pregnancy wastage among the two occupation groups. Also, the prevalence of the matrilineal system is much stronger here and the choice of this village helped us bring this important dimension on board.

Quantitative Survey

We decided to generate the database for our study through a quantitative survey of respondents from the two occupation groups. The different stages involved in the choice of the sample were as follows.

- A house-listing and census of *all* the households in the village. This, as noted, was done as part of the earlier survey in 2001. Establishing the occupation status of all workers in the village provided us the information needed to identify the beedi and agricultural labour households. A beedi household was defined as one where at least one female worker was a beedi worker; from among the rest (i.e. non-beedi households) an agricultural labour household was identified as one with at least one female agricultural labourer. The house-listing operation thus provided us with a sample frame of beedi and agricultural labour households.
- Within this frame, a random sample of 100 each of beedi and agricultural labour households was chosen. A detailed household-level enquiry was then conducted with the sample households. For the beedi households this was done as part of the earlier survey (in 2001) and for the agricultural labourers as part of the present one (in 2002).
- After the detailed household-level enquiry, an individual-level enquiry was conducted on various aspects of maternal health and pregnancy wastage with one or two ever-married women in each of these households. Where the household had two or more ever-married women, the oldest and the youngest among them were chosen in order to capture intergenerational differentials, if any. In all, we surveyed 211 respondents, of whom 69 were beedi workers, 110 agricultural labourers and the remaining 32 were 'secondary' or 'marginal workers' who, more often than not, identified themselves as 'housewives'.

Qualitative Enquiries

Qualitative enquiries constituted a very minor part of our survey, mainly due to our lack of expertise in this area. All the same, we did gather some qualitative information through the following steps.

- Using a checklist of questions, we conducted a village-level enquiry with some key informants on the beedi industry and beedi workers in the village. A similar exercise was carried out to get information

on the agricultural economy and the agricultural labourers.

- We held discussions with key informants, such as the ANM, the doctor in the health centre and some older women in the village, on the general health status of the village women, health facilities available and aspects of pregnancy wastage; we did not use a checklist of questions for this.
- We also held discussions on pregnancy wastage with some health personnel, particularly the private doctors, in the nearby taluka headquarters. These doctors happen to be the providers of abortion services in the vicinity.
- Detailed discussions were also held with some key informants from the older generation on the *Aliya Santhana* system.
- While we were conducting the quantitative survey, we noted down some qualitative information on almost all the respondents. These details very often provided us a picture of the general milieu in which to situate the quantitative data.

Questionnaires Used

Table 3 provides some details on the questionnaires used in our survey, such as the issues on which information was solicited, etc. We managed to collect a substantial volume of largely quantitative data on pregnancy wastage and related socio-economic and cultural issues in the village. However, only a small proportion of the data collected—relating to the last two schedules in the table—has been analysed and presented here.

Ethical Issues

Pregnancy wastage is a very sensitive, personal issue, particularly when it is induced. For us, the most important ethical issue was therefore the need to maintain strict confidentiality and privacy of the respondents. However, it did raise a couple of problems for our survey.

While obtaining the respondents' consent for being interviewed on such a sensitive matter was essential, getting their written consent was not practical since more than two-thirds of them were illiterate. We therefore decided to begin each interview by making clear to the respondent that she would be asked a number of sensitive questions but that she was free to refuse answering any question she did not want to answer or even call off the interview whenever she wished. However, there were not many instances of such refusal. Only in one case did the respondent refuse to answer any of the questions and the interview had to be called off. In another case, the respondent wanted to know, after the interview, whether confidentiality would be maintained. She was assured that the name of the village as well as that of each and every respondent would be disclosed to no one. In a number of cases the respondents wanted to know the purpose of the interview and once we explained that, they had no hesitation in answering our questions.

The more important problem we faced while conducting the interviews was in terms of 'gate-keeping'. Maintaining confidentiality meant that the interview had to be conducted in private, with no one other than the respondent and the investigator being present. This was not always possible, given the informal nature of the rural milieu. 'Gate-crashing' by close relatives, neighbours and children (who were on their summer vacation) was a major impediment, which we tried to overcome in two ways. First, we tried to time the interviews either in the late morning or later in the afternoon, when the male adults were likely to be away at work. Secondly, when we could not enforce 'gate-keeping', we tried to conduct the most sensitive part of the interview, i.e. relating to the pregnancy and abortion history of the respondent, in private. While we were largely successful in overcoming this problem, in a couple of cases we had to abandon the interview halfway. In one case, when the respondent was giving us details about the induced abortion she had undergone, her mother, who was listening to the conversation from the kitchen, insisted that her daughter had not had any induced abortion. In another case, when the respondent was telling us about the repeated spontaneous abortions she had suffered, her husband turned up. Sensing her reluctance to continue, we decided to call off the interview.

An unavoidable consequence of the need to maintain privacy is that the quality—as well as the quantity—of information gathered may not be up to the mark. For instance, this requirement constrained us to delete certain issues and procedures from our survey. First of all, we completely left out of our ambit premarital and extramarital pregnancies. Since our respondents were all ever-married women, our only question on pre or extramarital pregnancy related to their general attitude regarding recourse to induced abortion in such pregnancies. Due to this exclusion, it is likely that the

Table 3 : Details on the Questionnaires Used in the Survey

No.	*Questionnaire*	*Items of Information Solicited*	*Unit for Which Data Were Obtained*	*Respondent*	*Interviewer*	*When the Survey Was Conducted*
1.	House-listing schedule	Demographic details; educational status; occupational status	All members of all the households in the village	Any adult in the household; preferably head of the household	Research investigator (male)	February–March 2001
2.	Village-level questionnaire—beedi workers	Organisation of beedi industry in the village; general details on wage system in operation; the health problems of beedi workers, etc.	Village-level enquiry	Some key informants like older beedi workers; beedi contractors, etc.	Research investigator (male)	April 2001
3.	Household schedule—beedi workers	Economy of the household as a whole; details on educational status including educational aspirations of the children; demographic and fertility details on the women; work norms, working conditions, wages received, health status of workers	Households (100) and one or two beedi workers in each household	Any adult for the household details; and concerned beedi worker(s)	Research investigator (male)	May–August 2001
4.	Village-level questionnaire—agricultural labourers	General details on the agricultural economy of the village; wage systems prevalent in the village; agricultural calendar and average number of work-days in the crop economy	Village-level enquiry	Key informants like knowledgeable agriculturists, etc.	Research investigator (male)	May 2002
5.	Household schedule—agricultural labourers	Economy of the household as a whole; details on educational status including educational aspirations of children; demographic and fertility details; work norms, working conditions, wages received and health status of agricultural labourers	Households (100) and one or two female agricultural labourers in each household	Any adult for household details; and concerned agricultural labourers	Researcher investigator (male)	June–Sept 2002
6.	Pregnancy wastage survey—respondents' background	General demographic details on the respondent; family system (*Aliya Santhana*); decision-making in the family; details on live births for the respondent; details on antenatal and postnatal care; lifestyle and consumption details.	One or two ever-married women in the 200 survey households —sample size: 211	Ever-married women concerned	Research investigator (female)	February–August 2002

(contd)

No.	Questionnaire	Items of Information Solicited	Unit for Which Data Were Obtained	Respondent	Interviewer	When the Survey Was Conducted
7.	Schedule on family planning and abortion	General demographic details; general health status of the respondent; contraceptive practices and preferences; details on abortions and stillbirths; attitude towards induced abortion. Details gathered on pregnancy wastage include: history of pregnancy wastage; medical details on each of the episodes; health/abortion provider(s); pre-and post-wastage complications; approx. cost incurred; psychological state; decision-making regarding induced abortion, etc.	One or two ever-married women in the 200 survey households—same ones as in the above questionnaire—sample size: 211	Ever-married women concerned	Joint coordinator of the project—Dr K. Susheela	February–August 2002

rate of abortion in our sample village has been understated.

Secondly, we did not attempt to crosscheck the data provided by the respondents. In surveys involving relatively sensitive socio-economic issues—say, landholding—crosschecking procedures are often adopted in order to ensure quality of data gathered. The landholding data provided by a landlord is often crosschecked either with the land records in the village or with some persons in the village who are likely to be knowledgeable about his household (as, for example, his tenant). Given the highly sensitive and personal nature of our topic, we decided against using any such crosschecking procedure. This, we believe, may be another source of underestimation of the abortion rate in our survey village.

Classification of Respondents into Socio-Economic Groups

As noted earlier, the basic objective of the study was to broadly understand the manner in which socio-economic factors specific to our region, viz., social sector development, matrilineal family system and fertility transition, affect pregnancy wastage among beedi workers and agricultural labourers. In order to do this, we partitioned the 211 respondents surveyed by us in the following way.

Occupation-wise classification

The respondents were classified into three groups: beedi workers, agricultural labourers and home workers (or marginal or subsidiary workers). Beedi workers comprised women who rolled beedis at home after getting the necessary inputs from the contractor and delivered the rolled beedis back to him. For this they received a cash wage. They had to go to the depot maintained by the contractor in an adjacent village to both receive the inputs and deliver the output. Beedi-rolling is a relatively recent activity and came to the village in the early 1970s. Agricultural labourers—usually landless—whose wages are generally paid in kind, perhaps form the poorest strata in the village. Home workers comprise women who identified themselves as housewives. Apart from working at home, they also looked after their kitchen gardens and worked occasionally as agricultural workers in their own small farms. They did not receive any wages—in cash or kind.

Family system-wise classification

On the basis of information gathered from each respondent, we classified them into two groups: those who follow the matrilineal system and those who follow the patrilineal system.

Table 4: Distribution of Respondents by Different Socio-Economic Criteria

Criterion of Classification	*Socio-Economic Group*		*Number of Respondents*	*Percent of Respondents*
Occupation	All beedi workers		69	32.7
	All agricultural labourers		110	52.1
	All home workers		32	15.2
	Total number of respondents		211	100.0
Family system and occupation	Matrilineal	Beedi workers	41	19.4
		Agricultural labourers	106	50.2
		Home workers	19	9.0
		Total matrilineal	166	78.7
	Patrilineal	Beedi workers	28	13.3
		Agricultural labourers	4	1.9
		Home workers	13	6.2
		Total patrilineal	45	21.3
Fertility change and occupation	Young	Beedi workers	31	14.7
		Agricultural labourers	16	7.6
		Home workers	14	6.6
		Total young	61	28.9
	Old	Beedi workers	16	7.6
		Agricultural labourers	71	33.6
		Home workers	11	5.2
		Total old	98	46.4
	Others	Beedi workers	23	10.9
		Agricultural labourers	23	10.9
		Home workers	6	2.8
		Total others	52	24.6

Classification based on fertility transition

As has been mentioned earlier, rapid fertility decline in the study region set in around the late 1980s or early 1990s. In order to capture the impact of this process on pregnancy wastage we divided the 211 respondents into three groups: 'young' respondents, comprising those who had their *first pregnancy* in or after the year 1991; 'old' respondents, comprising those who had their *last pregnancy* before or in 1991; and 'others', i.e. those who had their first pregnancy before 1991 and their last pregnancy after 1991.

Classification on the basis of social sector development

We did not have a separate category to capture this dimension because the previous classification—i.e. 'young', 'old' and 'others'—seemed to capture it rather well. As we shall see later, the 'young' have a much higher rate of literacy and exposure to mass media compared to the 'older' ones. This is not surprising, since social sector development and exposure to mass media and urban influence are important factors behind fertility transition.

Classification based on type of pregnancy wastage

Of the 211 respondents, 138 had suffered no pregnancy wastage; the remaining 73 were classified into three groups on the basis of the type of pregnancy wastage experienced:

Type I: Those who had had one or more *induced abortions*; they could also have had one or more spontaneous abortions and stillbirths.

Type II: Those who had had no induced abortion but one or more *spontaneous abortions*; they could also have had one or more stillbirths.

Type III: Those who had had only one or more *stillbirths.*

For the sake of convenience, we shall refer to Type I as the 'induced abortion' group. This group had 17 respondents, while Type II had 40 and Type III 16 respondents.

The classification of all 211 respondents by the broad criteria we have just set out—occupation, family system, social sector advances and fertility transition—is given in Table 4.

In this context, a couple of clarifications regarding the manner in which these different classifications are

used in our analysis are in order. First of all, the three modes of classification overlap; but the sub-groups obtained by cross-classification of the respondents are often so small in number that any meaningful comparison across sub-groups is not possible. Therefore, wherever we have attempted such comparisons across sub-groups, the results should be seen essentially as plausible hypotheses that need to be studied in greater detail.

The second clarification refers to the manner in which the socio-economic dimensions often exercise their influence. Such influence may not always be confined to the specific social group defined by the particular dimension, but may extend across other social groups as well. This is particularly the case if the socio-economic dimension happens to be a growing, dominant tendency. Thus, apart from the 'exposed group', exposure to mass media and urban lifestyles may also affect the non-exposed groups. Similarly, our impression is that the influence of the matrilineal system in terms of modulating discrimination against women—and providing them a degree of autonomy—extended beyond the communities that followed the *Aliya Santhana* system. In situations like this, for a comparison to be meaningful, it would need to be made not between the social groups identified within our sample, but between our sample as a whole and a social set-up where the dominant tendency is absent. Unfortunately, we have not been able to access such alternate scenarios and hence have had to fall back on our impressions regarding these issues.

So much for the methodological issues. But before we start discussing the various aspects of pregnancy wastage among our sample respondents, it is necessary to provide some details on their important socio-economic attributes and the variation of these attributes across the various socio-economic groups identified by us.

Socio-Economic Characteristics of Respondents

The respondents—both the agricultural labourers and beedi workers—belong to the poorer strata of society. This is clearly brought out in Table 5, which provides data on some indicators on level of living in the context of beedi workers. Poverty—income poverty in particular—appears to be widespread among them. The per capita monthly income of the beedi worker households in our sample is as low Rs 324, which is just about 23 per cent of the per capita monthly income (Rs 1,417) in Karnataka state for the year 1999–2000. In fact, it is *lower* than the all-India poverty line—which was Rs 336 per capita per month in 1999–2000.

Unfortunately, we have not yet been able to analyse the income data for agricultural labour households, but it is unlikely that their level of living is better than the beedi households. If anything, it is likely to be worse. Some general data that we gathered from our respondents regarding their normal consumption habits, given in Table 6, indicate this quite clearly.

The only item consumed on a regular basis by all our respondents is rice. Nearly three-fourths of them reported that they also consume 'milk/curd' on a regular basis. Our impression is that this is likely to be in very small quantities, usually some milk as part of the tea consumed. Nearly two-thirds reported that they consume fish on a regular basis (fish happens to be the major source of nutrition for the poor all over the

Table 5: Some Indicators of Level of Living of Beedi Households in the Survey Village

Indicator of Level of Living		*Value for the Beedi Households in the Survey Village*
Income (Rs per month)	Per household	2,012
	Per capita	324
Housing and sanitation	Per cent of *kachcha* houses	30.7
	Per cent without toilet facility	62.4
	Per cent without electricity	39.6
Landlessness	Per cent of landless households	76.2
Per cent of households indebted	To any source	36.6
	To informal sources	13.9
Per cent of literacy (for 5+ ages)	Male	84.7
	Female	74.6

Source: Village Survey (2001).

Table 6: Some Indicators of Consumption Norms among Sample Respondents

Social group		*Percentage of respondents who consumed the following items on a regular basis*								
		Rice	*Pulses*	*Vegetables*	*Fruits*	*Oil*	*Milk/Curd*	*Eggs*	*Fish*	*Other non-vegetarian items*
Occupation	Beedi workers	100.00	7.5	4.5	6.0	25.4	85.1	Nil	67.2	Nil
	Agricultural labourers	100.00	Nil	13.2	Nil	29.2	68.9	1.9	60.4	Nil
	Home workers	100.00	Nil	19.4	Nil	51.6	83.9	Nil	80.6	Nil
Family system	Matrilineal	100.00	1.9	13.8	1.9	29.4	74.4	1.3	63.1	Nil
	Patrilineal	100.00	4.5	2.3	2.3	38.6	84.1	Nil	75.0	Nil
Age	Young	100.00	3.4	15.3	3.4	23.7	81.4	Nil	62.7	Nil
	Old	100.00	Nil	10.5	1.1	33.7	72.6	2.1	67.4	Nil
	Others	100.00	6.0	8.0	2.0	50.0	78.0	Nil	66.0	Nil
All respondents		100.00	2.5	11.3	2.0	31.4	76.5	1.0	65.7	Nil

Source: Village Survey (2002).

Dakshina Kannada region). And nearly a third said that they consume oil on a regular basis—again, it is likely to be in very small quantities. Apart from these, consumption of items like pulses, fruits, vegetables and eggs is extremely rare; and not a single respondent reported that she consumes any 'non-vegetarian item' (other than fish) regularly: they are consumed very rarely, if at all. And this is despite the fact that there was not a single 'vegetarian' among our respondents.

This general picture seems to apply across all the socio-economic groups we have identified. The consumption norm among agricultural labourers seems to be as poor as that among the beedi workers; if anything, in terms of 'fish' and 'milk/curd' consumption, it appears to be poorer.

While poverty appears to be a general feature of all our respondents, they do vary in terms of other socio-economic aspects. Some of these are presented in Tables 7 and 8.

With more than three-fourths of the respondents reporting that they follow *Aliya Santhana*, it is clear that matriliny is the predominant system. But it is also clear that the system has weakened considerably over the years: today, only about 40 per cent of the respondents live in their parental home. While patrilocality does not seem to be significant-—with only about a tenth of respondents saying that they live in their in-laws' home—the tendency towards nucleation of the family appears to be quite strong. Close to half the respondents reported that they do not stay with either parents or in-laws, but have set up their own (possibly nuclear) household. The proportion of female-headed households, at around 38 per cent, is much lower than the percentage claiming to follow *Aliya Santhana*, indicating thereby that the system is not followed in a strict sense by a number of them. The rapid replacement of bride price by dowry also points to this. All in all, the matrilineal system does survive, but not in its pristine form.

Our sample respondents are not only poor but also socially backward. Only about a third of them are literate; and at 17.9, the average age at marriage is slightly lower than the legal minimum for girls. But their exposure to mass media, and hence also to urban influences, appears to be quite high (see Table 8). Compared to the poor in the country as a whole, our sample respondents are much more exposed to radio (20 per cent for the poor in the country compared to 61 per cent for our respondents), TV (19 per cent and 43 per cent respectively) and newspapers (4 per cent against 9 per cent). Interestingly, our respondents' exposure to films is of a lower order compared to the poor in the country as a whole. It should be noted here that the data from NFHS-II refers to the poor in both urban and rural areas of the country. The poor in the rural areas would have an even lower degree of exposure to mass media, and the differentials in comparison with our respondents, who are also the rural poor, would be sharper.

While this is the general picture, considerable variation exists across different social groups in terms of these attributes. Turning first to the occupational groups, beedi workers are considerably younger compared to agricultural labourers; they are also more literate and exposed to the mass media to a much larger extent. Agricultural labourers, in contrast, have a very low level of literacy—just about a seventh of them are literate; their exposure to the mass media and urban influences

Table 7: Some Demographic and Socio-Economic Characteristics of Respondents Belonging to Different Social Groups

Basis of classification	*Social group*	*Average age in years*	*Per cent distribution by marital status*				*Average age at marriage*	*Per cent of literates*	*Per cent who follow Aliya Santhana*	*Pattern of residence: per cent who*			*Percent of female-headed households*	*Per cent who reported*	
			Currently married	*Widowed*	*Deserted*	*Divorced/ separated*				*stay in parental home*	*stay in in-laws' home*	*set up separate home*		*bride price paid in her marriage*	*dowry paid in her marriage*
Occupation	Beedi workers	34.7	91.3	4.3	4.3	Nil	18.7	57.8	59.4	36.2	10.1	53.6	36.2	11.6	56.5
	Agricultural labourers	46.6	68.5	22.5	8.1	0.9	17.3	13.5	96.4	47.3	4.5	48.2	40.0	56.0	25.7
	Home workers	36.0	86.6	13.3	Nil	Nil	18.4	50.0	58.1	25.8	29.0	45.2	32.3	3.3	53.3
Family system	Matrilineal	41.6	77.7	15.1	6.6	0.6	17.9	27.1	100.0	50.3	4.8	44.8	40.0	42.3	35.6
	Patrilineal	40.0	81.8	15.9	2.3	Nil	17.7	59.1	Nil	6.7	28.9	64.4	28.9	2.3	48.9
Age	Young	28.8	91.8	4.9	3.3	Nil	20.3	49.2	77.0	59.0	16.4	24.6	36.1	6.6	73.8
	Old	56.5	60.8	28.9	9.3	1.0	15.8	20.7	90.9	33.7	7.1	59.2	43.2	56.8	18.2
	Others	38.5	96.2	1.9	1.9	Nil	18.8	42.3	75.0	35.3	7.8	56.9	34.6	31.4	39.2
All respondents		41.2	78.6	15.2	5.7	0.5	17.9	33.3	78.6	40.5	10.0	49.5	37.6	33.8	40.1

Source: Village Survey (2002).

Table 8: Exposure to Mass Media for Respondents Belonging to Different Socio–Economic Groups

Basis of Classification	*Social group*	*Percentage of respondents who -*				
		Read a newspaper/ magazine at least once a week	*Listen to radio at least once a week*	*Watch television at least once a week*	*See a film at least once a week*	*Are members of some social/ political organisation*
Occupation	Beedi workers	16.4	62.7	56.7	7.5	9.0
	Agricultural labourers	2.8	60.4	32.1	5.7	0.9
	Home-workers	12.9	54.8	45.2	Nil	Nil
Family type	Matrilineal	9.4	67.1	45.6	6.3	4.4
	Patrilineal	7.0	39.5	25.6	2.3	Nil
Age	Young	15.3	59.3	37.3	3.4	5.1
	Old	7.6	57.6	37.0	4.3	1.1
	Others	4.0	70.0	50.0	10.0	6.0
	All respondents	9.0	61.2	42.8	5.5	3.5
All India (rural and urban) 1998–99	For persons with low standard of living index	4.1	20.3	18.5	8.2	NA
	For the population as a whole	20.8	36.5	45.7	10.6	NA
Karnataka (rural and urban), for the population as a whole, 1998–99		27.9	60.9	58.4	19.7	NA

Note: NA = Not Available

Source: 1. Village Survey (2002).
2. For all-India and Karnataka figures, NFHS-II 1998–99.

is also of a lower order compared to beedi workers, but is still significantly higher when compared to the poor in the rest of the country. They are overwhelmingly matrilineal—much more so than beedi workers, even though the prevalence of this system is also quite significant among the latter. Thus, while there are important differences between the two occupation groups, they are not sharp or absolute but often of degree.

A similar situation obtains when we turn to the social groups identified by 'age'. As explained earlier, this classification was based on the respondents' reproductive period. The 'young' are those whose reproductive period began on or after 1991, and the 'old' are those whose reproductive period ended on or before that year. As one would expect—and as is clear from Table 7—the 'young' are indeed much younger than the 'old': their average age, at 28.8 years, is only half that of the older group (56.5 years). The 'young' are also much more literate; their average age at marriage, at a reasonably high 20.3 years, is 4.5 years higher than that of the 'old'. The incidence of matriliny—while quite high—is nevertheless lower among the 'young'. But what is really surprising is that the extent of matrilocality is the highest among the 'young' as compared to the other two 'age' groups. But perhaps this finding is more reflective of a 'life cycle effect' than an increase over time in this attribute. The practice among those who follow *Aliya Santhana* today seems to be that the girl continues to stay in her maternal home after marriage but 'sets up her own home' after a few years, possibly when the children have 'grown up'. This seems to be borne out by the high proportion of those who have 'set up their own homes' among the 'old' and 'other' age groups. A similar 'life cycle effect' appears to operate even in the case of exposure to mass media. Even though the 'young' have a higher level of such exposure compared to the 'old', the difference between the two does not seem to be significant. Since the burden of child care is heavier for the 'young', it is possible that this acts as a constraint on sustained, regular exposure to mass media like the television and radio. The high degree of such exposure in the 'other' age group perhaps testifies to this. There is one more fact—a disturbing one—to be noted from Table 7: the almost complete and rapid displacement of bride price by dowry among the 'young'.

Where the two groups identified by family system are concerned, there is hardly any difference between them in terms of demographic characteristics. But the degree of literacy among those who follow the matrilineal system is much lower compared to those who follow the patrilineal system. Surprisingly, there is hardly any difference between the two in terms of average age at marriage; if anything, the figure is slightly higher for those who follow the matrilineal system. The usual positive relationship between literacy and age at marriage does not seem to hold in this case. It is also interesting to note that exposure to mass media is significantly higher among those who follow the matrilineal system. Does all this indicate that among the followers of the matrilineal system (though they tend to be socially more backward, as borne out by the high degree of illiteracy among them), women enjoy a relatively higher degree of autonomy? The high degree of matrilocality, the predominance of female-headed households and the prevalence of bride price to a significant degree among them perhaps do support such a contention. But some evidence we have gathered on decision-making in the household presents a mixed picture and suggests that such an equation would be far too simplistic.

Decision-making in the Household

Table 9 presents data on some aspects of decision-making in the domestic sphere. It gives the percentage of respondents who reported that decisions on certain issues is taken by 'herself', unmediated by others in the household. These issues can be broadly divided into two major groups. Issues on which decisions have to be taken frequently—on a day-to-day basis—and where the woman is likely to have a higher degree of decision-making powers unmediated by other, particularly male members in the household, form one group. They include, for example, decisions regarding what to 'cook', 'purchasing daily necessities', 'purchasing clothes for herself or children' and 'obtaining health care for herself or children'. The other group relates to issues on which decisions have to be taken once in a while or issues of considerable importance, such as those relating to respondent's marriage and 'purchasing consumer durables for the household'.

The first set of issues—the 'day-to-day' decisions within the domestic sphere—appears to be essentially the preserve of women in the household. In an overwhelming percentage of cases, the respondent herself takes decisions regarding the purchase of clothes for herself or children and seeking health care for herself or children. The corresponding percentage with respect to

Table 9: Decision-making in the Household among Different Social Groups of the Respondents

Basis of classification	*Social group*	*Day-to-day issues*						*Longer-term, more important issues*				
		Percentage where respondent took the decision herself						*Per cent where the respondent herself decided on buying consumer durables*	*Decision regarding respondent's marriage (per cent distribution)*			
		Buying daily household requirements	*Buying clothes for herself*	*Buying clothes for children*	*Obtaining health care for herself*	*Obtaining health care for children*	*What items to cook*		*Parents/ elders without consulting her*	*Parents/ elders with her consent*	*Herself with consent of parents /elders*	*Herself without consent of parents/ elders*
Occupation	Beedi workers	50.7	94.2	94.2	88.4	95.6	100.0	55.1	17.4	82.6	Nil	Nil
	Agricultural labourers	32.7	94.5	93.6	95.5	93.6	100.0	31.8	38.5	60.6	0.9	Nil
	Home workers	16.1	93.5	96.8	100.0	96.8	100.0	22.6	19.4	77.4	Nil	3.2
Family type	Matrilineal	35.2	94.5	93.9	95.8	93.9	100.0	37.0	29.3	69.5	0.6	0.6
	Patrilineal	40.0	93.3	95.6	88.9	95.6	100.0	40.0	26.7	73.3	Nil	Nil
Age	Young	29.5	96.7	96.7	96.7	96.7	100.0	39.3	3.3	93.4	1.6	1.6
	Old	27.0	89.0	88.0	90.0	88.0	100.0	23.0	50.5	49.5	Nil	Nil
	Others	60.8	98.0	100.0	96.1	100.0	100.0	64.7	17.1	82.4	Nil	Nil
	All respondents	36.2	94.3	94.3	94.3	94.3	100.0	37.6	28.7	70.3	0.5	0.5

Source : Village Survey (2002).

buying daily necessities for the household is significantly lower, at around a third of the respondents. But a closer look at the data reveals that this is largely due to the fact that, while mediation by men is quite low, other women in the household also take part in the decision-making. Thus it appears that there is an autonomous sphere within the household where decision-making rests largely with the women. What is interesting is that this phenomenon can be observed across all socio-economic groups, with no significant variations across them.

The picture is quite different when we come to more important, longer-term issues. The extent of autonomy enjoyed by women on these issues, predictably perhaps, is altogether of a lower order; and this is particularly true of decisions regarding marriage. Out of a total number of 211 respondents, only two reported taking the decision about whom to marry—one with the consent of parents and elders, and the other without. In around 30 per cent of the cases, the marriage was arranged without even consulting the girl.

It is important to note that the degree of autonomy with respect to these longer-term, more weighty issues varied considerably across social groups. The extent of autonomy enjoyed by beedi workers—who are younger, more literate, have a higher exposure to mass media and urban influences and have access to cash wages—compared to that enjoyed by agricultural labourers is significantly higher. Similarly the 'young'—who again are more literate and comprise a higher proportion of beedi workers with access to cash income—have much more autonomy compared to the 'old' respondents.

While both these findings are what one would generally expect, a comparison between those who follow the matrilineal system and those who follow the patrilineal one gives a result that is counter-intuitive. Respondents who follow the matrilineal system in fact appear to have a *lower* degree of autonomy compared to those who follow the patrilineal system. A closer look at the data reveals that this is almost solely due to the fact that agricultural labourers constitute a large proportion of the respondents who follow the matrilineal system and, as we have noted, this occupation group enjoys a relatively lower degree of autonomy compared to other occupation groups. A cross-classification of the data by family system and occupation group helps resolve this paradox to a considerable degree (see Table 10). Among both beedi workers and home workers, those following the matrilineal system appear to have a *higher* degree of autonomy compared to those subscribing to the patrilineal system. While the reverse appears to be the case when we consider the two sub-groups among the agricultural labourers, the comparison is in fact spurious

Table 10: Decision-Making among Respondents Cross-Classified by Occupation and Family Type

Occupation	*Family system*	*No. of respondents in the group*	*Decision-making with respect to longer-term, more important issues*				
			Per cent where the respondent herself decided on buying the consumer durable	*Decision regarding respondent's marriage (per cent distribution)*			
				Parents/ elders without consulting her	*Parents/ elders with her consent*	*Herself with consent of parents/ elders*	*Herself without consent of parents/elders*
Beedi workers	Matrilineal	41	58.5	12.2	87.8	Nil	Nil
	Patrilineal	28	50.0	25.0	75.0	Nil	Nil
Agricultural workers	Matrilineal	106	31.1	39.0	60.0	0.9	Nil
	Patrilineal	4	50.0	25.0	75.0	Nil	Nil
Home workers	Matrilineal	19	27.8	11.1	83.3	Nil	5.6
	Patrilineal	13	15.4	30.8	69.2	Nil	Nil

Source: Village Survey (2002).

for the simple reason that there are only four respondents who belong to the patrilineal sub-group in this occupation—a sample size that is far too small for any meaningful comparison.

It must be noted here, however, that none of the factors discussed thus far can be viewed in isolation, for not only do they all interact with one another, they are also often at cross-purposes. The process of modernisation, for example, with its increasing literacy, exposure to outside world and a tendency towards nucleation of families, may in fact run counter to the tradition of matriliny in the region. The consequences for female autonomy of such an interaction would then be negative: the emergence of dowry in the area, even among those who follow matriliny, appears to be a case in point. But there could also be a situation where positive, mutual reinforcement of these factors is the stronger tendency. Our claim is that such a situation exists, at least as of now, in our survey village—and possibly in our study region.

An obvious caveat is in order at this stage. The aspects of autonomy that we have dealt with so far, confined as they are to the domestic sphere, are of a limited nature. And our only defence in this regard is that female autonomy, even in this limited sense, does not exist in any significant sense in most other parts of the country. However what is more relevant from our standpoint is that this autonomy, however limited, does seem to extend to decisions regarding health care provision for the mother and the child. The question now is: does such autonomy, involving aspects of mother and child health, translate into free, informed choice with respect to reproductive rights in general and abortion rights in particular?

PREGNANCY WASTAGE: EXTENT, COMPONENTS AND VARIATION AMONG SOCIAL GROUPS

Some Overall Measures of Pregnancy Wastage

Table 11 gives some gross measures of pregnancy wastage for our sample respondents as a whole. The measures used by us are: (*a*) the gross rate of pregnancy wastage which is defined as the number of pregnancy wastages per 100 pregnancies; (*b*) the net rate of pregnancy wastage, which is the number of pregnancy wastages per 100 live births; (*c*) the number of pregnancy wastages per respondent; and (*d*) the incidence of pregnancy wastage, which is defined as the percentage of women in the group (or any sub-group) who have undergone pregnancy wastage.

Considering our sample as a whole, nearly a third of them have suffered pregnancy wastage at some time or other in their reproductive span; and nearly a tenth of their pregnancies were wasted. According to NFHS data for 1998–99, the gross abortion rate for the country as a whole was 8.1 per 100 pregnancies, while it was lower for rural areas at 7.4. At 10.6, the figure for our sample respondents is around 47 per cent higher than the rate for rural India. The gross abortion rate for Karnataka as a whole (i.e. rural and urban combined) was, at 7.2, just

Table 11: Some Measures of Pregnancy Wastage for Sample Respondents

Category of respondents	*No. of respondents in each group*	*Total no. of pregnancies in each group*	*Total no. of pregnancy wastages in each group*	*Measures of pregnancy wastage*				*No. of pregnancies per respondent*	*No. of live births per respondent*
				Gross rate of pregnancy wastage (per unit)	*Net rate of pregnancy wastage (per cent)*	*No. of pregnancy wastages per respondent*	*Incidence of pregnancy wastage (per cent)*		
Those with any pregnancy wastage	73	448	108	24.1	31.8	1.49	100.0	6.14	4.65
Those without any pregnancy wastage	138	568	Nil	Nil	Nil	Nil	Nil	4.12	4.12
All respondents	211	1016	108	10.6	11.9	0.51	34.6	4.82	4.31

Source: Village Survey (2002).

about two-thirds the rate for our sample.

As pointed out earlier, our estimate of pregnancy wastage is likely to be lower for a number of reasons. First, we had excluded premarital and extramarital pregnancies from our survey. While wastage—particularly in the form of induced abortion—rates may be very high for these pregnancies, the actual weight of pregnancies of this nature in the overall number of pregnancies may be quite low. Given this, it is debatable how far this exclusion has affected our estimates. Secondly, our sample includes only poor, largely illiterate working women and does not cover the better-off, better educated women in the village. Since available evidence indicates that pregnancy wastage rates—for induced abortions in particular—are likely to be higher for these sections, our rate is likely to be an underestimation for the village or the region as a whole. Thirdly, respondents frequently tend to understate pregnancy wastage, either because of memory lapse or because they are reluctant to provide information on such a sensitive issue (which, again, would be largely regarding induced abortions). Lastly, our data relates to lifetime pregnancies and pregnancy wastages among our respondents and is therefore not an indication of current rates. If there is a tendency for abortion rates to increase over time—again, this seems to be so for induced abortions—our rate would be an understatement of the current rate.

Our justification for using our (under)estimates for further discussion is twofold. First, we do not think that the margin of error is so high as to vitiate any further analysis. By and large, we followed the methodology used in NFHS surveys to collect our data. Live births were used as a 'peg' to get pregnancy and pregnancy wastage histories of respondents; we believe that this helped us reduce problems associated with memory lapse. Since we managed to establish an excellent rapport with our respondents, we were able to reduce errors due to wilful mis-statements by them. As noted earlier, our estimates are broadly in line with NFHS estimates; if anything they are higher. Secondly, we are using our estimates largely to provide some broad, general hypotheses regarding variations in pregnancy wastage across various social groups. In so far as the errors in estimation do not show any systematic bias in favour of (or against) some social groups—and we have no reason to believe that they do—such an analysis, we believe, is legitimate.

Coming back to Table 11, a couple of points merit attention. The first is that the number of pregnancies per respondent, or the rate of pregnancy, is significantly higher for the 'affected' group, i.e. those with any pregnancy wastage, than for those without any pregnancy wastage (the 'unaffected' group). Since a considerable number of pregnancies get wasted in the affected group, the number of live births per respondent or children ever-born (CEB) per woman—which is a good measure of past fertility—also get considerably reduced for this group and, consequently, so does the fertility gap between the two groups. While the pregnancy rate for the affected group is nearly 50 per cent higher than that for the unaffected group, the corresponding fertility gap is just 13 per cent. This points to the role of pregnancy

wastage in fertility behaviour—a role that takes two distinct forms, often for distinct social groups. In a context where fertility transition has taken hold or is under way, as in our study region, 'voluntary wastage' or induced abortion may be a means for achieving the small family norm. In sharp contrast, where fertility transition has not taken place, a high rate of pregnancy may in fact be a response to a high rate of 'involuntary pregnancy wastage', such as spontaneous abortions and stillbirths. Pregnancy wastage here plays a role similar to that of infant mortality. This is in keeping with our perspective that if fertility transition or behaviour has strong social underpinnings, so does pregnancy wastage. We may also note here that while the role of infant mortality in fertility transition is well recognised and established, the role of pregnancy wastage in fertility behaviour has not received adequate attention in the literature.

A second point to note from the table is that a majority—close to two-thirds—of the respondents did not suffer pregnancy wastage. Thus, only a third of the respondents accounted for all the pregnancy wastages. Consequently, if we consider just the affected group, the rates of pregnancy wastage are high: nearly a fourth of all pregnancies, and a third of all live births, were wasted in this group. From this it seems that pregnancy wastage tends to get clustered in relatively small groups for whom rates of wastage can be very high.

This phenomenon of clustering is even more striking if we consider certain sub-groups within the affected group as, for example, those with multiple pregnancy wastages (Table 12). This sub-group, which comprises about a seventh of the total number of respondents, accounts for nearly 60 per cent of the total number of pregnancy wastages. The rate of pregnancy wastage for this sub-group is high: nearly 30 per cent of their pregnancies and 40 per cent of their live births are wasted. Their vulnerability to pregnancy wastage is over four times as high as that for the respondents as a whole. Part of the reason for this is their high 'vulnerability' to pregnancy itself. Their rate of pregnancy, at 7.45 per respondent, is very high indeed, more than ten times the rate for the respondents as a whole. Though the corresponding gap in CEB is lower—at 22 per cent—it is still significant. It is interesting that for a sub-group with only one pregnancy wastage, this gap between the rate of pregnancy for the sub-group and the respondents as a whole vanishes totally due to pregnancy wastage. Such clustering of pregnancy wastage among highly vulnerable groups has an obvious policy implication, and identifying such clusters and exploring the socio-economic and

Table 12: Pregnancy Wastage for Different Groups of Respondents

Category of respondents	*No. of respondents in the group*	*No. of pregnancies in the group*	*No. of pregnancy wastages in the group*	*Measures of pregnancy sastage*			*No. of pregnancies Per respondent*	*No. of Live births per respondent*
				Gross rate of pregnancy wastage	*Net rate of pregnancy wastage*	*Relative index of vulnerability to wastage*		
Those with any pregnancy wastage								
Those with pregnancy wastage	44 (20.9)	232 (22.8)	44 (40.7)	19.0	23.4	195	5.27	4.27
Those with multiple pregnancy wastage	29 (13.7)	216 (21.3)	64 (59.3)	29.6	42.1	433	7.45	5.24
All those with any pregnancy wastage	73 (34.6)	448 (44.1)	108 (100.0)	24.1	31.8	289	6.14	4.65
Those without any pregnancy wastage	138 (65.4)	568 (55.9)	Nil (0.0)	Nil	Nil	Nil	4.12	4.12
All respondents	211 (100.0)	1016 (100.0)	108 (100.0)	10.6	11.9	100	4.82	4.31

Note: 1. Relative index of vulnerability to wastage for a group is defined as: (percentage contribution of the group to total wastage x 100) / (percentage contribution of the group to total number of respondents).
2. Figures in brackets give column percentages.

Source: Village Survey (2002).

medical causes underlying such clustering would help in targeting measures for reducing such wastage.

This leads us to another important issue regarding pregnancy wastage, viz., the components of pregnancy wastage.

COMPONENTS OF PREGNANCY WASTAGE

Pregnancy wastage for a group of women (as a whole) depends on: (*a*) the size of the affected group or the 'cluster'; (*b*) the rate of wastage within the affected group; and (*c*) the pregnancy rate for the affected group. In fact, the rate of pregnancy wastage for the group as a whole can be expressed in a simple multiplicative way as follows:

$R_g = I_n \times r_g \times p_r$, where

R_g = gross rate of pregnancy wastage for the group as a whole;

I_n = incidence of wastage, i.e. percentage of women within the group who have undergone any pregnancy wastage;

r_g = gross rate of pregnancy wastage considering only the affected group (this gives the intensity of wastage within the affected group); and

p_r = relative pregnancy rate, i.e. pregnancy rate for the affected group divided by the pregnancy rate for the group as a whole.

Similarly, net pregnancy wastage rate for the group as a whole (R_n) can be expressed as:

$R_n = I_n \times r_n \times f_r$, where

I_n = incidence as defined above;

r_n = net pregnancy wastage rate for the affected group; and

f_r = relative fertility rate as given by the ratio of CEB per woman for the affected group to CEB per woman for the group as a whole.

This scheme of component analysis can be used for any socio-economic group and the variations, if any, in the overall rates of pregnancy wastage across socio-economic groups could be related to the variations in their components. This would provide us with some clues about the factors underlying variations in pregnancy wastage. While we shall attempt such an exercise later in the report, for the present we confine our attention to the sample respondents as a whole. The components of pregnancy wastage for them are given in Table 13.

Apart from the multiplicative scheme of components just described, total pregnancy wastage rate can also be

Table 13: Multiplicative Components of Pregnancy Wastage for Sample Respondents

Category of respondents	*Gross rate of pregnancy wastage (R_g)*				*Net rate of pregnancy wastage (R_n)*			
	Total value (R_g)	*Incidence (I_n)*	*Rate for the affected group - r_g*	*Relative pregnancy rate (p_r)*	*Total value (R_n)*	*Incidence (I_n)*	*Net rate for the affected group - r_n*	*Relative fertility rate (f_r)*
All sample respondents	10.6	34.6	24.1	1.27	11.9	34.6	31.8	1.08

Source: Village Survey (2002).

Table 14: Components of Pregnancy Wastage by Type of Wastage

Category of respondents		*No. of pregnancy wastages by type*				*Gross rate of pregnancy wastage*				*Net rate of pregnancy wastage*			
		Induced abortion	*Spontaneous abortion*	*Still births*	*Total*	*Rate of induced abortion*	*Rate of spontaneous abortion*	*Rate of still birth*	*Total (gross) rate*	*Rate of induced abortion*	*Rate of spontaneous abortion*	*Rate of still birth*	*Total (net) rate*
Those with any pregnancy wastage	Single wastage	10 (22.7)	21 (47.7)	13 (29.5)	44 (100.0)	4.3	9.1	5.6	19.0	5.3	11.2	6.9	23.4
	Multiple wastage	11 (17.2)	35 (54.7)	18 (28.1)	64 (100.0)	5.1	16.2	8.3	29.6	7.2	23.0	11.8	42.1
	Total	21 (19.4)	56 (51.9)	31 (28.7)	108 (100.0)	4.7	12.5	6.9	24.1	6.2	16.5	9.1	31.8
All respondents in the survey		21 (19.4)	56 (51.9)	31 (28.7)	108 (100.0)	2.1	5.5	3.1	10.6	2.3	6.2	3.4	11.9
NFHS, 1998–99	All-India (Rural)	NA	NA	NA	NA	1.1 (14.9)	4.2 (56.8)	2.1 (28.4)	7.4 (100.0)	1.2	4.5	2.3	8.0
	Karnataka (Rural & Urban)	NA	NA	NA	NA	0.9 (12.5)	4.0 (55.6)	2.3 (31.9)	7.2 (100.0)	1.0	4.3	2.5	7.8

Note: 1. NA = Not Available
2. Figures in brackets give percentage distribution of pregnancy wastages by type.

Sources: Village Survey (2002); NFHS–II, 1998–99.

divided into three additive components corresponding to three different types of pregnancy wastage, viz., induced abortions, spontaneous abortions and stillbirths. These are presented in Table 14.

If we compare the rates of pregnancy wastage by different types of wastage for our respondents as a whole with the corresponding rates for rural India or Karnataka as given by NFHS–II, it is clear that all three rates are higher for our sample. However, in terms of the contribution of different types of wastage to overall wastage, the pattern for spontaneous abortion and stillbirths seems to be similar. The contribution of these two involuntary forms of pregnancy wastage is around 80 per cent for our sample, with the corresponding figures for rural India and Karnataka being higher, at around 85 and 88 per cent respectively. The contribution of induced abortions to total pregnancy wastage—about a fifth—in our sample is thus higher compared to rural India or Karnataka, where the corresponding figure is at around a seventh.

Our data shows that compared to those with single pregnancy wastage, respondents with multiple pregnancy wastage have significantly higher rates of wastage for all the three types of wastage. This differential is particularly sharp in the case of involuntary wastage. The rate for spontaneous abortions is extremely high for the multiple pregnancy wastage group, which is four times more prone to spontaneous abortions than the sample population as a whole. As pointed out earlier, this group also has a high pregnancy rate (7.45 pregnancies per woman), and while the high level of pregnancy wastage has brought down the group's fertility rate to 5.24, this rate is still significantly higher—by about 20 per cent—compared to our sample as a whole. It is therefore in this group that high pregnancy rate shows up as a response to high involuntary pregnancy wastage.

So far, we have dealt with the rates and components of pregnancy wastage for our sample population as a whole without considering their variations across socio-economic groups. A look at this issue is therefore in order.

RATES OF PREGNANCY WASTAGE FOR DIFFERENT SOCIO-ECONOMIC GROUPS

Table 15 gives some measures of pregnancy wastage for the different socio-economic groups identified by us. It appears that while there is some amount of variation in gross and net rates of pregnancy wastage across socio-economic groups, the variation is not significant except, perhaps, in the case of classification by 'age', where the highest and the lowest values differ by around 25 to 30 per cent. The other two measures, viz., incidence and vulnerability index, do vary considerably across socio-economic groups, but their pattern of variation does not coincide with the pattern displayed by the other two standard measures. Thus, for example, among the three groups identified on the basis of 'age', the 'young' have the highest rate of pregnancy wastage going by the two standard measures of pregnancy wastage, whereas they have the lowest rate for incidence and vulnerability index. And while the indices for pregnancy rate and fertility rate vary considerably across social groups, their variation is (positively) associated with the latter two indices (i.e. incidence and vulnerability) rather than with the two standard indices.

One reason why the standard measures do not show

Table 15: Some Measures of Pregnancy Wastage for Different Socio-Economic Groups

Scheme of classification	*Socio-economic group*	*Gross rate of pregnancy wastage*	*Net rate of pregnancy wastage*	*Incidence of pregnancy wastage*	*Index of vulnerability to pregnancy wastage*	*Pregnancy rate (per woman)*	*No. of Live Births Per woman*
Occupation	Beedi workers	10.5	11.7	29.0	82	3.99	3.57
	Agricultural labourers	10.4	11.6	38.2	110	5.42	4.86
	Home workers	11.7	13.3	34.4	104	4.53	4.00
Family system	Matrilineal	10.3	11.5	33.1	94	4.66	4.18
	Patrilineal	11.5	13.0	40.0	122	5.40	4.78
Age	Young	12.2	13.9	26.2	61	2.56	2.25
	Old	10.9	12.2	39.8	124	5.81	5.18
	Others	9.3	10.3	34.6	102	5.60	5.08
	All respondents	10.6	11.9	34.6	100	4.82	4.31

Source: Village Survey (2002)

significant variation across socio-economic groups might be the classificatory scheme we have adopted. As noted earlier, these three schemes of classification—by occupation, family system and 'age'—overlap and hence, perhaps, tend to 'cancel out' the variations they produce. A more disaggregated classificatory scheme should provide a wider degree of variation in the rates of pregnancy wastage. Table 16 attempts to do this by cross-classifying the three occupations by the two family systems (giving six sub-categories) and by the three 'age' groups (giving nine sub-categories).

As we can see from Table 16, the various measures of pregnancy wastage do show a higher degree of variation across the disaggregated sub-groups, even for the two standard measures of gross and net rates of pregnancy. But this is partly due to the fact that the number of observations in some of these groups is very low, as for example among the patrilineal agricultural labourers (four respondents) and the home workers in the 'other' age group (six respondents). If we delete these sub-groups, the extent of variation does come down for each indicator, but still remains substantial. But apart from these variations, the table also brings out some other results, a couple of which reinforce the earlier results based on a broader classification of respondents.

As with the broader classification, the extent of variation is higher in the case of incidence and vulnerability index, compared to the two standard indices—i.e. gross and net rates of wastage.[2] Secondly, the extent of variation for all indicators of wastage is higher in the case of sub-groups obtained by cross-classifying occupation groups with age groups, compared to those obtained by the cross-classification of occupations by the family system. This appears to be true for the pregnancy rate and fertility rate as well. It therefore seems that all these variables are much more sensitive to the socio-economic factors that facilitated fertility transition in the region than to factors associated with the nature of the family system.

Thirdly, the table also brings out quite sharply the strong, positive correlation between pregnancy rate and the various rates of pregnancy wastage. But there seems to be a curious pattern here for which we have no explanation: while in the case of classification of occupation groups by family system, pregnancy rate is correlated with all the four indices of pregnancy wastage, in the case of classification of occupation by age groups this relationship seems to hold only for the last two indices

Table 16: Measures of Pregnancy Wastage for Different Socio-Economic Sub-Groups

Scheme of classification	*Socio-economic sub-groups*		*No. of respondents*	*Measures of pregnancy wastage*				*Pregnancy rate per women*	*No. of live births per women*
				Gross rate of pregnancy wastage	*Net rate of pregnancy wastage*	*Incidence of pregnancy wastage*	*Index of vulnerability to pregnancy wastage*		
Occupation & Family system	Matrilineal	Beedi workers	41	9.1	10.0	19.5	57	3.22	2.93
		Agr. labourers	106	10.6	11.9	38.7	113	5.41	4.83
		Home workers	19	10.2	11.4	31.6	72	3.58	3.21
	Patrilineal	Beedi workers	28	11.9	13.5	42.9	119	5.11	4.50
		Agr. labourers	4	4.3	4.5	25.0	49	5.75	5.50
		Home workers	13	13.0	14.9	38.5	151	5.92	5.15
Occupation & Age	Young	Beedi workers	31	14.1	16.4	29.0	76	2.74	2.15
		Agr. labourers	16	5.1	5.4	12.5	25	2.44	2.31
		Home workers	14	15.6	18.5	35.7	70	2.29	1.93
	Old	Beedi workers	16	17.1	7.6	31.3	74	5.31	4.94
		Agr. labourers	71	10.8	12.1	39.4	122	5.72	5.10
		Home workers	11	15.4	18.2	54.5	214	7.10	6.00
	Others	Beedi workers	23	10.5	11.7	26.1	94	4.57	4.09
		Agr. labourers	23	10.6	11.9	52.2	136	6.57	5.87
		Home workers	6	Nil	Nil	Nil	Nil	5.83	5.83
All respondents			211	10.6	11.9	34.6	100	4.82	4.31

Source: Village Survey (2002).

for pregnancy wastage, viz., incidence and vulnerability.[3] It is also worth noting that, while in the first scheme of classification the variations in the four indices for wastage are more or less in line with each other, in the second scheme there are important disjunctions, in that higher values of gross and net rates of pregnancy wastage for a sub-group are not necessarily associated with higher values of incidence and vulnerability index. Thus, for example, among the 'young' respondents, beedi workers have high gross and net rates of wastage but low incidence and vulnerability, as do the young home workers. We had noted similar disjunctions even in the case of the broader classificatory scheme adopted earlier and we shall return to its implications shortly.

As we have seen, the various measures of pregnancy wastage, as well as pregnancy and fertility rates, vary considerably across age groups. But the manner in which such variation occurs seems to be different for the three occupation groups. If we compare the older generation with the younger one in each occupation group, a distinct pattern emerges. The young agricultural labourers clearly show *lower* pregnancy wastage in *all* four indices. Between the old beedi workers and the young ones, while two of the variables (incidence and vulnerability) hardly change, the gross and net rates record sharp *increases*. Home workers show a third pattern: between the old and the young home workers, the gross and net rates remain more or less constant, but the other two indices register a *decline*. If we compare the young respondents as a whole with the old ones (Table 15), the gross and the net rates register some—but not very significant—increases, but the incidence and vulnerability indices show a rather sharp decline. But this overall pattern hides at least three distinct trends. The moderate increase in (overall) gross and net rates is the result of a sharp increase in one (beedi workers), a decline in another (agricultural labourers) and constancy in the third (home workers). And the rather sharp decline in incidence and vulnerability is confined to only agricultural labourers and home workers, with very little change in the case of beedi workers.

The same broad pattern of difference between the young and the old, and the distinct trends within it, shows up even when we divide the social groups by number of pregnancies (Table 17). The decline in incidence between the older and younger generations is due solely to a sharp decline in the number and proportion of respondents who have undergone multiple pregnancy wastage. The percentage of respondents with a single pregnancy wastage is seen to be higher for the young compared to the old. On the other hand, the intensity of pregnancy wastage within each group, particularly that with multiple pregnancy wastages, increases sharply, leading to overall increases in the gross and net rates.

Table 17: Measures of Pregnancy Wastage for Those with Single and Multiple Wastages among Different Socio-Economic Groups

Scheme of classification	*Social group*	*Those with single pregnancy wastage*							*Those with multiple pregnancy wastage*						
		No. of respondents		*Gross rate of wastage*	*Net rate of wastage*	*Vulnerability index*	*Pregnancy rate (per woman)*	*No. of live births per woman*	*No. of respondents*		*Gross rate of wastage*	*Net rate of wastage*	*Vulnerability index*	*Pregnancy rate (per woman)*	*No. of live births per woman*
		Number	*Per cent of total no. in the group*						*Number*	*Per cent of total no. in the group*					
Occupation	Beedi workers	14	20.3	21.5	27.4	195	4.64	3.64	6	8.7	48.4	93.8	490	5.17	2.67
	Agri. Labourers	24	21.8	16.3	19.5	195	6.13	5.13	18	16.4	28.4	39.7	414	7.44	5.33
	Home workers	6	18.8	30.0	42.9	195	3.33	2.33	5	15.6	21.6	27.6	431	10.20	8.00
Family system	Matrilineal	33	19.9	19.1	23.6	195	5.24	4.24	22	13.3	30.1	43.1	420	7.10	4.96
	Patrilineal	11	24.4	18.6	22.9	195	5.36	4.36	7	15.6	28.3	39.5	476	8.57	6.14
Age	Young	14	23.0	27.5	37.9	195	3.64	2.64	2	3.2	71.4	250.0	490	3.50	1.00
	Old	19	19.4	17.9	21.8	195	5.58	4.58	20	20.4	26.1	35.3	422	8.25	6.10
	Others	11	21.2	14.7	17.2	195	6.82	5.82	7	13.5	36.4	57.2	449	6.29	4.00
All respondents		44	20.9	19.0	23.5	195	5.27	4.27	29	13.7	29.6	42.0	433	7.45	5.24

Source: Village Survey (2002)

While the three occupation groups exhibit distinct patterns in terms of the manner in which pregnancy wastage has undergone change over time, when it comes to fertility decline all three of them show the same pattern. All of them witnessed a sharp decline in both pregnancy and fertility rates, particularly in the 1990s. This implies that the exact manner in which fertility transition is linked to pregnancy wastage varies from one occupation group to another.

In the case of beedi workers, the incidence and vulnerability indices, which were relatively low among the older lot, remain more or less low and constant, even for the young, but there is a sharp increase in gross and net rates of wastage. Does this mean that a proportion of the young among beedi workers have resorted to voluntary abortions as a means of family limitation or spacing? The agricultural labourers provide a sharp contrast to this. As noted earlier, this occupation group, which had relatively high levels of pregnancy wastage—particularly in terms of the vulnerability index—among its 'older generation', witnesses a sharp decline in these levels along with fertility transition. It appears that for the older among them, as well as for those in the 'other age group', a high pregnancy rate is a response to high levels of pregnancy wastage, and a sharp decline in fertility has gone hand-in-hand with a sharp decline in wastage. Improvements in health care facilities would have led to a decline in involuntary abortions, thus providing an incentive for family limitation; and fewer pregnancies, in turn, would have led to lower wastage. It is also possible that this occupation group, particularly the young among them, does not use voluntary abortions as a means for family limitation.

COMPONENTS OF PREGNANCY WASTAGE FOR DIFFERENT SOCIO-ECONOMIC GROUPS

Table 18 gives the relevant information for the broad socio-economic groups. As we have noted earlier, nearly a third of our respondents have experienced one or more pregnancy wastages. The gross rate of pregnancy wastage (or intensity of wastage) for this affected group is quite high, with about a fourth of their pregnancies being wasted. An overwhelming proportion of this wastage is involuntary, with induced abortions accounting for just about a fifth of total wastage. The affected group also has a significantly higher pregnancy rate compared to the respondents as a whole (which is shown by the relative pregnancy rate, with a value higher than unity), thus establishing a link between pregnancy wastage and fertility rate.

While this is the overall picture, there is considerable variation across the various socio-economic groups in this context, and the variation appears to be particularly striking in the case of groups identified by age. If we compare the respondents in the 'older age group' with

Table 18: Components of Pregnancy Wastage for Different Socio-Economic Groups

Scheme of classification	*Socio-economic group*	*Gross pregnancy wastage rate*	*Multiplicative components for gross pregnancy wastage rate*			*Relative fertility rate*	*Additive components for gross pregnancy wastage rate*		
			Incidence (per cent)	*Intensity (i.e. rate for the affected group)*	*Relative pregnancy rate*		*Induced abortion rate*	*Spontaneous abortion rate*	*Rate of stillbirths*
Occupation	Beedi workers	10.5	29.0	30.2	1.20	0.94	3.3 (31.0)	3.3 (31.0)	4.0 (37.9)
	Agricultural labourers	10.4	38.2	22.1	1.23	1.07	1.7 (16.1)	6.0 (58.1)	2.7 (25.9)
	Home workers	11.7	34.4	23.9	1.42	1.23	1.4 (5.9)	7.6 (64.7)	2.8 (23.5)
Family type	Matrilineal	10.3	33.1	24.3	1.28	1.08	2.2 (21.2)	5.6 (53.8)	2.6 (25.0)
	Patrilineal	11.5	40.0	23.5	1.22	1.06	1.6 (14.3)	5.3 (46.4)	4.5 (39.3)
Age	Young	12.2	26.2	32.8	1.42	1.08	5.1 (42.1)	2.6 (21.1)	4.5 (36.8)
	Old	10.9	39.8	22.9	1.20	1.03	1.4 (12.9)	7.0 (64.5)	2.5 (22.6)
	Others	9.3	34.6	22.7	1.18	1.01	1.7 (18.5)	4.1 (44.4)	3.4 (37.0)
All respondents		10.6	34.6	24.1	127	1.08	2.1 (19.4)	5.5 (51.9)	3.1 (28.7)

Note: Figures in brackets give percentage distribution of pregnancy wastage by type.
Source: Village Survey (2002).

the younger ones, the latter have moderately higher gross pregnancy wastage compared to the former, but this increase is not due to an increase in incidence. In fact, the proportion of women experiencing pregnancy wastage is lower among the young. Nevertheless, this relatively small group has a significantly higher intensity compared to the affected group in the older generation. It is interesting to note that the relative pregnancy rate for the younger group is higher than the corresponding rate for the older group. This is basically because while a decline in pregnancy rate is a general phenomenon among the young—with the decline taking place both for the affected group as well as the others among them—the rate at which the decline has occurred is lower among the affected group. If we consider the sample as a whole, the pregnancy rate for the older group is 5.81, which declines to 2.5 for the young—a decline by 56 per cent. If we consider only the affected group, the decline is of a lower order: the pregnancy rate for the older group is 6.96 and it declines by 46 per cent to 3.63 for the young. This could mean that there is a section among young respondents who have fallen behind, for whatever reason, in terms of reduction in pregnancy rates, but given the near-universal acceptance of the two-child norm in the region, the number and proportion of unwanted pregnancies are high, and they resort to induced abortions as a means of family limitation. This contention gets additional support if we look at the components of pregnancy wastage by type. The rate of induced abortions among the young is almost three times that among the older generation. The increase in the gross abortion rate between the old and the young is solely due to an increase in voluntary abortion rate. Compared to the older group, the overall rate of involuntary abortions (which includes both spontaneous abortions and stillbirths) has come down in the case of the younger lot, but it is noteworthy that this decline is solely due to a sharp decline in the number of spontaneous abortions.

A similar pattern is discernible when we compare beedi workers with agricultural labourers.

The former have a lower incidence, but a higher intensity of wastage compared to the latter. The induced abortion rate for beedi workers is nearly twice that for agricultural labourers. And while the pregnancy rate for the affected group among the beedi workers is significantly higher than the corresponding rate for the rest among them, the fertility rate for the affected group is in fact lower. So it is likely that a section of the beedi workers—as in the case of a section among the young—takes recourse to induced abortion as a means of family limitation.

If our conjecture is valid—i.e. that a section among both the young and the beedi workers use induced abortion to limit family size—then it should be among *young beedi workers* that this tendency is the most striking. Table 19, which contains data that is further disaggregated, seems to support this contention.

If we look at our scheme of classification by occupation and age, among the nine sub-groups identified, the young beedi workers have an overall gross pregnancy wastage rate which is the third highest among all groups. Though the affected group comprises a relatively small percentage of women, the intensity of wastage within this affected group is high—the second highest among the nine sub-groups. And this wastage is largely due to induced abortions, the rate for which (at 8.2) is the highest in this sub-group. In fact, induced abortions account for nearly 60 per cent of the total pregnancy wastage in this group, which is the only one among the nine where voluntary abortions account for more than half of the total pregnancy wastage. The relative pregnancy rate for this sub-group is also quite high, indicating that, for some reason, a relatively small section of women in the sub-group have experienced fertility decline. And it appears that at least some among them would have taken recourse to induced abortions to attain a small family size comprising of, say, just two children. This is borne out by the sharp fall in relative fertility rate, which is around 25 per cent lower than the relative pregnancy rate.

If we look at the data relating to the other classification scheme based on occupation and family system, only one (the matrilineal beedi workers) of the six sub-groups show characteristics similar to the ones noted in the earlier paragraph. It has the lowest incidence but the highest intensity of pregnancy wastage among the six sub-groups; a majority of this wastage—again, close to 60 per cent—is due to induced abortion, the highest among all six sub-groups. And there is a sharp fall—of around a third—from the relative pregnancy rate to relative fertility rate. The contrast this sub-group provides with the patrilineal beedi workers on these aspects is also quite striking.

If these two sub-groups—each obtained by a different scheme of classification—have these similarities, it stands to reason that the socio-economic group where

these two overlap, i.e. *young beedi workers from the matrilineal system*, is the one where these characteristics will tend to get most accentuated, which is to say that only a small section among them with unwanted pregnancies take recourse to induced abortions as a method of family limitation. Our earlier discussion on the socio-economic correlates of relatively higher female autonomy in our study region supports this contention. However, before elaborating on this, it would be useful to note two other points that emerge from Table 19.

First, a striking contrast to this pattern among a section of the beedi workers emerges when we look at the agricultural labourers, particularly when we compare the older and younger generations among them. Among the older agricultural labourers, while the spread of pregnancy wastage—as given by incidence—is high, the intensity of wastage within the affected group is low, with nearly 90 per cent of it being involuntary. A substantial section among them must have resorted to a high pregnancy rate as an insurance against high pregnancy wastage: the pregnancy rate for the affected group is as high as 6.86, while for the rest it is only 4.98. But this mode of fertility adjustment seems to have more or less disappeared for the young agricultural labourers, among whom we find a sharp decline in pregnancy wastage, along with a sharp decline in pregnancy and fertility rates. The pregnancy rate for the older generation of agricultural labourers was 5.72 and it declined sharply to 2.44 for the younger agricultural labourers; the decline in fertility rate is equally dramatic, from 5.10 to 2.31 (see Table 16).

It is also worth noting that the type of fertility adjustment prevalent among the older generation of agricultural labourers has not disappeared entirely among the younger ones. This is because, while there has been a sharp decline in the spontaneous abortion rate between the old and the young, the rate of stillbirths has registered a substantial increase among the young compared to the old. So it appears that a small section of the young agricultural labourers—about an eighth of them—still have a high pregnancy rate as an insurance against increasing and high rates of stillbirths. For this affected group, the pregnancy rate is 5.00 (as against 2.07 for the rest in this group of young agricultural labourers) and the fertility rate is 4.00 (as against 2.07 for the rest).

While the young beedi workers with a matrilineal background and the older generation of agricultural labourers (also mostly from a matrilineal background) do provide a striking contrast in terms of the manner in which pregnancy wastage and fertility rates are related, it is not our contention that these two patterns exhaust all the possibilities. Consider, for example, the occupa-

Table 19: Components of Pregnancy Wastage for Different Socio-Economic Sub-Groups

Scheme of classification	*Socio-economic sub-groups*		*Gross pregnancy wastage rate*	*Multiplicative components for gross pregnancy wastage rate*			*Relative fertility rate*	*Additive components for gross pregnancy wastage rate*		
				Incidence (per cent)	*Intensity (i.e. rate for the affected group)*	*Relative pregnancy rate*		*Induced abortion rate*	*Spontaneous abortion rate*	*Rate of stillbirths*
Occupation & Family system	Matrilineal	Beedi workers	9.1	19.5	40.0	1.16	0.77	5.3	2.3	1.5
		Agr. labourers	10.6	38.7	22.3	1.23	1.07	1.7	6.1	2.8
		Home workers	10.2	31.6	26.9	1.21	0.99	Nil	7.4	2.9
	Patrilineal	Beedi workers	11.9	42.9	25.8	1.08	0.91	1.4	4.2	6.3
		Agr. labourers	4.3	25.0	12.5	1.39	1.27	Nil	4.3	Nil
		Home workers	13.0	38.5	22.2	1.52	1.36	2.6	7.8	2.6
Occupation & Age	Young	Beedi workers	14.1	29.0	35.3	1.38	1.04	8.2	2.4	3.5
		Agr. labourers	5.1	12.5	20.0	2.05	1.73	Nil	Nil	5.1
		Home workers	15.6	35.7	35.7	1.23	0.93	3.1	6.3	6.3
	Old	Beedi workers	7.1	31.3	27.3	0.83	0.65	2.4	3.5	1.2
		Agr. labourers	10.8	39.4	22.9	1.20	1.04	1.2	6.9	2.7
		Home workers	15.4	54.5	21.1	1.34	1.25	1.3	11.5	2.6
	Others	Beedi workers	10.5	26.1	27.5	1.46	1.18	Nil	3.8	6.7
		Agr. labourers	10.6	52.2	20.3	1.00	0.89	3.3	5.3	2.0
		Home-workers	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Source: Village Survey (2002).

tion group which we have termed 'home workers'. While the pattern of relationship between pregnancy wastage and fertility adjustment among the older generation of home workers is more or less similar to that exhibited by the older generation of agricultural labourers, this similarity disappears when we compare the younger generations among the two occupation groups. While fertility transition has occurred among the home workers, unlike agricultural labourers, they have not witnessed any decline in pregnancy wastage. In fact, the rate of induced abortion has gone up considerably and involuntary abortions have come down only marginally. Within involuntary abortions, while the rate of spontaneous abortions has registered a decline, the rate of stillbirths has increased. Does this mean that a section of the young among home workers resorts to induced abortion as a means of family limitation, while another section still sees relatively higher pregnancy rate as an insurance against high involuntary wastage? Unfortunately, our small sample size does not permit us to examine this issue in any detail.

But the point we have made does bring out complexity of the relationship between pregnancy wastage and fertility transition. This relationship has many strands that vary across socio-economic groups, even in a localised region like our survey village. And this, we believe, supports a broad generalisation that many demographers emphasise, which is that fertility transition is a localised phenomenon, and its causes, the manner in which it comes about and its consequences vary, not only across regions but also across socio-economic groups within a region. And if pregnancy wastage is closely linked to fertility transition, the same generalisation should hold for that as well.

Returning to our discussion on the socio-economic group represented by young beedi workers following the matrilineal tradition, we have argued that they take recourse to induced abortions as a means of family limitation on a significant scale. If we recall our discussions on female autonomy, we had identified a *combination* of factors which seem to underlie the relatively higher level of autonomy in our study region. We had also said that while matriliny appears to provide a general cultural sub-stratum, a combination of other socio-economic factors is needed to facilitate such autonomy: access to education; access to non-farm employment (providing cash income); access to mass media and influence of urban values and lifestyle. The fact that young matrilineal beedi workers comprise the socio-economic group where these factors are most likely to merge, supports our hypothesis that the relatively higher degree of autonomy enjoyed by this social group may be a factor underlying their propensity to use—consciously—induced abortions as a means of family limitation.

But is this choice a free and informed one, made under enabling circumstances? A closer look at the phenomenon of induced abortions in our study region may help us answer this question.

INDUCED ABORTIONS

Out of our sample of 211 respondents, 17 had undergone induced abortion. Between them, these 17 respondents had experienced 26 pregnancy wastages, 21 induced abortions, two spontaneous abortions and three stillbirths. In this section we deal with three basic issues: (*a*) the characteristics of these 17 respondents and whether they differ from the rest of our respondents in any significant ways; (*b*) the reasons—as stated by the respondents—for undergoing induced abortion; and (*c*) abortion care available to the respondents.

Before proceeding on these three issues, it may be useful to establish the larger context within which decisions pertaining to them are taken, i.e. the attitudinal milieu. Ideally, we should have studied the attitude towards induced abortions of various sections of the population, male as well as female. Unfortunately we have not been able to do so; our data refer only to the attitudes expressed by our sample respondents—which may or may not reflect the overall attitudinal milieu. But even a limited understanding of this context, we believe, is worthwhile, since it refers to an important section of the village population, a section whose pregnancy wastage is our direct concern. Unlike involuntary abortions, induced abortions involve making conscious choices, which may, to a great extent, be moulded by the attitudinal milieu of the respondents.

Attitude towards Induced Abortion

There were basically two questions that we used to collect data on this aspect. The first was whether the respondent knew that abortion is now legal and the reasons for its legalisation. The second was about the circumstances under which the respondent felt it was all right to resort to induced abortion, as well as her views on the accessibility of abortion services. As it turned

out, the majority of respondents knew that abortion is legal, but very few knew why. The few who did venture to answer this question said that it had been legalised to 'control population growth'. We therefore felt that before asking them about the circumstances under which they would advocate abortion, it would be useful to discuss the reasons for its legalisation in more detail. We also thought that doing this would help us establish a better rapport with the respondents before we launched upon more sensitive questions. While it did do this, it also gave rise to a problem that establishing such a rapport frequently leads to in surveys involving sensitive issues, i.e. the problem of 'empathetic responses', where the respondent tries to give answers which she thinks are in line with the opinions held by the interviewer.

So, around a quarter of the way through our investigation—we had already conducted 61 interviews—we changed our procedure. For the remaining 150 respondents, we elicited answers to two sets of questions before starting on a detailed discussion on the reasons why abortion has been legalised. After this discussion, we requested the respondents (including the first 150) to once again respond to the second set of questions relating to the circumstances under which they would advocate abortion. Thus we have two sets of responses: the first set, *before discussions*, has 150 responses (Table 20); the second set of responses, *after discussions*, has 211 observations, which are given in Table 21. Even a casual look at the two tables makes it clear that the two sets of responses differ significantly except, of course,

Table 20: Attitude towards Induced Abortions among Sample Respondents—Before Discussions

Scheme of classification	*Social group*	*Percentage who know abortion is legal*	*Percentage who agreed that abortion is acceptable in the following circumstances*						*Percentage who want that abortion should be*		
			Mother's health is in danger	*Foetus is abnormal*	*Rape*	*Preferred method of contraception*	*Failure of contraception*	*Premarital or extra marital pregnancies*	*Banned*	*Available at low cost*	*Available on demand at any clinic, any time*
Occupation	Beedi workers	94.1	65.9	65.9	68.2	6.8	61.4	65.9	13.6	22.7	Nil
	Agricultural labourers	84.7	61.0	61.0	61.0	11.0	61.0	60.0	9.8	23.2	Nil
	Home workers	83.9	75.0	62.5	75.0	8.3	62.5	75.0	12.5	16.7	Nil
Family system	Matrilineal	86.1	60.8	60.8	61.7	10.0	60.8	60.0	10.8	16.7	Nil
	Patrilineal	93.2	77.4	67.7	77.4	6.5	64.5	77.4	12.9	38.8	Nil
Age	Young	93.8	56.3	56.3	56.3	8.3	50.0	56.3	10.4	20.4	Nil
	Old	80.2	67.2	68.8	67.2	15.6	68.8	68.8	14.1	23.4	Nil
	Others	94.0	71.1	68.4	71.1	2.6	63.2	68.4	7.9	21.1	Nil
	All respondents	86.7	64.7	62.7	65.3	9.3	61.3	64.0	11.3	22.0	Nil

Source: Village Survey (2002).

Table 21: Attitude towards Induced Abortions among Sample Respondents— After Discussions

Scheme of classification	*Social group*	*Percentage who know abortion is legal (before discussion)*	*Percentage who agreed that abortion is acceptable in the following circumstances*						*Percentage who want that abortion should be*		
			Mother's health is in danger	*Foetus is abnormal*	*Rape*	*Preferred method of contraception*	*Failure of contraception*	*Pre-marital or extra marital pregnancies*	*Banned*	*Available at low cost*	*Available on demand at any clinic, any time*
Occupation	Beedi workers	94.1	98.5	98.5	98.5	22.4	94.0	92.5	1.5	52.2	10.4
	Agricultural labourers	84.7	94.8	94.8	94.8	21.6	94.8	93.8	1.0	44.3	7.2
	Home workers	83.9	94.7	94.7	93.8	10.5	89.5	89.5	Nil	31.6	5.3
Family system	Matrilineal	86.1	95.9	95.9	96.6	21.6	94.6	93.9	0.7	45.3	6.8
	Patrilineal	93.2	95.5	95.5	95.5	15.9	88.7	86.4	2.3	43.1	11.4
Age	Young	93.8	96.7	96.7	96.7	18.0	93.4	90.2	Nil	44.3	4.9
	Old	80.2	93.0	93.0	93.1	24.1	79.3	89.7	2.3	49.4	11.5
	Others	94.0	100.0	100.0	100.0	15.9	100.0	100.0	Nil	38.6	6.8
	All respondents	86.7	96.2	96.2	96.2	20.8	94.0	92.9	1.1	44.8	8.2

Source: Village Survey (2002).

for the percentage who knew that abortion is legal. These differences may be due to three reasons: (*a*) the responses after discussions are perhaps more informed; (*b*) the rapport established through discussions may have reduced respondents' propensity to modulate their answers (which may therefore be more authentic); and (*c*) as noted earlier, the empathy that better rapport engenders may have affected the responses. For reasons which we hope will become clear shortly, the first two reasons, the positive ones, outweigh the negative one of empathetic responses, and for these reasons we would put more faith in the second set of responses—those after discussions—as being more authentic.

Turning to the responses obtained *before discussions*, we can see that Table 20 throws up a couple of important generalisations. First, a majority of our respondents appear to have what may be termed a 'liberal' attitude towards induced abortions. More than 85 per cent know it is legal and close to 90 per cent do not want it banned. Close to two-thirds approve of induced abortions in a number of circumstances or contingencies. While one can perhaps expect that a majority of women would approve of taking recourse to abortion for reasons of health (both of the mother and child), as also for pregnancies due to rape, what is perhaps surprising is that an almost equal proportion—nearly two-thirds—approve of it even in cases of pre or extramarital pregnancies. The reasons given for such approval were largely the following:

- It may be true that the girl has committed a mistake, but her life should not be ruined because of that mistake.
- Life in this society for an illegitimate child is a very difficult one—and one should think of such a child's future life.
- I have seen illegitimate infants abandoned immediately after birth; it is better to abort them than subject them to such treatment.

While the overall attitude can thus be characterised as being fairly liberal, it is also interesting to note that it is *not* permissive. This is clear from respondents' attitude towards access to abortions. While nearly 90 per cent of them do not want a ban on abortions, an overwhelming majority also want access to abortions to be restricted. They are certainly against it being available on demand, at any clinic, at any time, and only about a fifth want it made available at a low cost. They had basically two reasons for wanting to limit access to abortion: (*a*) they felt that free access would encourage premarital and extramarital relations, which are morally not acceptable and are still seen as 'mistakes'; (*b*) the second reason, which is much more pragmatic, was that free access would encourage repeated recourse to induced abortions, which would impact poorly on the mother's health.

This view, that repeated abortions, being 'operations', are not good for the mother's health, also seems to mould their attitude towards the use of induced abortions as a family planning technique. While a majority—close to 60 per cent—approve of abortion in the case of contraceptive failure, less than a tenth advocate it as a (preferred) method of contraception.

However, only about two-thirds of the 150 respondents expressed definite views; the responses that we elicited from the rest (before discussions) were vague and ambiguous, mainly due to lack of information and, more importantly, reluctance to divulge their real opinion to the interviewer. The extent of ambiguity also appeared to vary considerably across different social groups, which explains some of the 'anomalies' that can be observed in Table 20. For example, the younger generation appears to be much less liberal compared to the older one, even though it is better educated, much more exposed to urban influences, etc. This anomaly can probably be attributed to the higher degree of ambiguity that characterised their responses. The older generation, who had lived longer, had formed more definite views on these sensitive issues, and were also more willing to state them. The younger respondents, on the other hand, were much less willing to express their views, partly because of their need to project an image of moral probity, more so because all our respondents are ever-married women. In fact, our experience during the survey was that young unmarried girls—who often 'gatecrashed' the survey—were much more forthright and liberal in their views.

It was precisely because of the pervasive presence of such ambiguities that we decided to have extended discussions with each respondent. The data given in Table 21 indicate that the views expressed by the respondents did change considerably after these discussions. Perhaps the most striking difference post-discussion is that their views have become much more liberal. Only about 1 per cent want abortions to be banned (compared to about 11 per cent pre-discussion); and more than 90 per cent (compared to around 60 per cent earlier)

approve of abortions under various circumstances and contingencies, *including* pre and extramarital pregnancies.

But what is also striking is that despite becoming more liberal, their attitudes have still not become permissive. The majority of respondents still advocate restrictions on access. Less than a tenth wish for free, unfettered access; and less than half want access to be at a lower cost. And only about a fifth agree to abortion as a preferred method of contraception, even though its acceptance in case of contraception failure is almost universal.

Thus, though after discussion the respondents' attitudes became more liberal, they remained nuanced and well thought out. It is precisely because of this that we believe that the post-discussion views are more authentic. Formed, as they are, on the basis of better information and expressed with less reluctance because of better rapport, the nuances would perhaps have been lost if 'empathetic responses' were the major reason for the changes in attitude.

A pertinent question to ask at this stage would be: what role does the institution of matriliny—which, we have averred, provides a degree of female autonomy in our study region—play in moulding these remarkably liberal attitudes? An aspect of this liberalism—perhaps a surprising one—is that it extends even to issues like pre and extramarital pregnancies. If we recall our discussion on the rules governing the family in *Aliya Santhana*, we had noted that they provided a cultural sub-stratum, a milieu, for the development of a liberal attitude in relation to marriage, man–woman relationships, and pre and extramarital relationships. A liberal attitude towards induced abortions, particularly its advisability in the case of pre and extramarital pregnancies, would be a corollary of this.

But it is also noteworthy that the attitudes expressed *after discussion* reflect very little difference across different socio-economic groups. This is perhaps due to the fact that the matrilineal system has left its imprint not just on the communities following the system, but also on society as a whole. Considering that the matriliny was and still is a dominant system in that it is followed by an overwhelming majority in the region, this is not surprising.

There is another way the matrilineal system appears to have influenced the incidence of induced abortions. Our extensive enquiries with the sample respondents, doctors practising in the area and other knowledgeable persons from the older generations revealed that the practice of female foeticide—or infanticide—is practically absent in the region. This would certainly affect the rate of induced abortions in the region. The role of matriliny in this has to be underlined: since the continuation of the family lineage depends on the female child, the extent of son preference in the region appears to be very low. We had noted earlier that a two-child norm is more or less universally accepted. Our enquiries with the respondents revealed that the desired gender composition is almost always one male child and one female child. It is only when this gender composition is not achieved after the second birth that a third child is desired. But even this desire is almost universally gender-neutral. So the basis for female foeticide or infanticide is virtually absent. However, a note of caution is in order here: it is a moot point as to how long this positive dimension of gender relations can withstand the onslaught of the 'Sanskritisation' process, of which the emergence of dowry is a clear sign.

So far, we have been discussing the attitudes to abortion of our sample respondents as whole. But do the 17 respondents who have undergone one or more induced abortions also hold similar views? Do they differ from the rest in terms of socio-economic characteristics?

Characteristics of Those Who Have Undergone Induced Abortions

Demographic and socio-economic characteristics

Of the 17 respondents who have undergone induced abortions, 7 or 41 per cent are beedi workers (the corresponding percentage for the sample as a whole being 33), eight are agricultural labourers (47 per cent as compared to 52 per cent in the sample); and two (or 12 per cent) are home workers (as against 15 per cent in the sample). Thus the beedi workers seem more prone to access induced abortions compared to other two occupation groups.

As for the other socio-economic and demographic characteristics (Table 22), those who have had induced abortion are significantly younger—with an average age of 37.4 years—than the rest of the respondents (average age: 41.7 years) or those who have had other types of pregnancy wastage (average age: 45.0 years). They are all currently married, as opposed to three-fourths among the rest. They are also significantly more literate, and their age at marriage is slightly higher when compared

Table 22: Demographic and Socio-Economic Characteristics of Those Who Have Undergone Induced Abortions

Occupation group	Category of respondents by pregnancy wastage status	Average age (in years)	Per cent distribution by marital status				Average age at marriage (Years)	Per cent of literates	Per cent who follow Aliya Santhana	Pattern of residence (per cent)			Percent of female-headed households	Per cent who reported	
			Currently married	Widowed	Deserted	Divorced/ separated				who stay in parental home	who stay in in-laws' home	who set up separate home		bride price paid in her marriage	dowry paid in her marriage
All respondents	Those with induced abortions	37.4	100.0	Nil	Nil	Nil	18.6	47.1	76.5	47.1	11.8	41.2	29.4	41.2	52.9
	Rest of the respondents	41.7	76.7	16.6	6.2	0.5	17.8	32.1	78.8	39.9	9.8	50.3	38.3	33.2	38.9
	Those with other type of wastage (but no induced abortion)	45.0	75.0	17.9	7.1	Nil	16.6	30.4	74.5	32.7	9.1	58.2	41.8	42.6	37.0
Beedi workers	Those with induced abortions	30.7	100.0	Nil	Nil	Nil	19.6	71.4	71.4	57.1	14.3	28.6	42.9	Nil	85.7
	Rest of the respondents	35.2	90.3	4.8	4.8	Nil	18.6	56.5	58.1	33.9	9.7	56.5	35.5	12.9	53.2
Agricultural labourers	Those with induced abortions	44.0	100.0	Nil	Nil	Nil	18.0	25.0	100.0	50.0	Nil	50.0	25.0	87.5	12.5
	Rest of the respondents	52.0	66.0	24.3	8.7	1.0	17.2	12.6	96.1	47.1	4.9	48.0	41.2	52.9	26.5
Home workers	Those with induced abortions	34.0	100.0	Nil	Nil	Nil	18.0	50.0	Nil	Nil	50.0	50.0	Nil	Nil	100.0
	Rest of the respondents	36.1	85.7	14.3	Nil	Nil	18.4	50.0	63.3	27.6	27.6	44.8	34.5	3.5	50.0

Source: Village Survey (2002).

to the rest. In sum, in terms of social sector advances—and fertility transition—they seem to be ahead of the other respondents. This pattern, of those who have had induced abortions being younger and more literate—and marrying late—is clearly visible among beedi workers and agricultural labourers; however, it is not as clear or marked among the home-workers.

As for the incidence of the matrilineal system, looking at the pattern for the sample households as a whole, it appears that there are no significant differences between those who have undergone induced abortions and the rest. A closer look at the data reveals that this is largely because the pattern varies across the three occupational groups. Among the beedi workers, those who have undergone induced abortions have a distinctly higher incidence of the matrilineal system compared to the rest; among the agricultural labourers this difference does not appear to be significant—although those who have had induced abortions do have a slightly higher incidence of matriliny—for the simple reason that an overwhelming proportion of the respondents from both groups follow the matrilineal system. Among home workers, on the other hand, both respondents who have undergone induced abortions are from the patrilineal system, while most—19 out of 30—of the rest follow the matrilineal system.

Lifestyle indicators

Given that the respondents who have undergone induced abortions are younger and more literate, one would expect them to be more exposed to the mass media and urban influences. And this is indeed so (Table 23). While their exposure to the print media, radio and the films is higher than for the rest, it is interesting to note that there is hardly any difference between the two groups in terms of exposure to television. We had noted earlier that one reason for lower exposure to television could be that the younger generation bears a heavier burden in terms of childcare responsibilities. Perhaps they find it easier to reconcile these responsibilities with listening to the radio rather than watching television.

Table 23: Indicators of Lifestyle and Level of Living for Those with Induced Abortions

Classification by status of pregnancy wastage	*Lifestyle indicators—percentage of respondents who*					*Indicators of level of living: percentage of respondents who consumed following items on a regular basis*								
	read newspaper/ magazine at least once a week	*listen to radio at least once a week*	*watch TV at least once a week*	*see a film at least once a month*	*are members of some social/ political organisation*	*Cereals*	*Pulses*	*Vege-tables*	*Fruits*	*Milk/ curd*	*Eggs*	*Fish*	*Oil*	*Other non-veg items*
Respondents with induced abortions	17.6	70.6	41.2	12.5	Nil	100.0	6.3	Nil	Nil	75.0	Nil	75.0	Nil	Nil
Rest of the respondents	8.2	60.3	42.9	4.9	3.2	100.0	2.1	6.9	2.1	76.6	Nil	64.9	34.0	Nil
Respondents with other types of wastage but no induced abortions	6.0	60.0	38.0	3.9	2.0	100.0	1.9	9.6	Nil	71.2	3.8	65.4	32.7	Nil

Source: Village Survey (2002).

While respondents in the induced abortion category are more exposed to mass media than the other respondents, they are hardly better off in terms of standard of living. All our respondents belong to the poorer strata of society and survive mainly on rice and fish.

Aspects of decision-making

If the respondents with induced abortions are more literate, more exposed to mass media and urban influences, have better access to non-agricultural employment, such as beedi rolling, which provides cash income, and have a higher incidence of matriliny, does all this translate into a relatively higher degree of autonomy for them? Going by our data on household decision-making from our survey, the answer would be yes (Table 24).

We had noted earlier that due to a number of factors specific to our study region, women, particularly those belonging to the poorer strata, in the region perhaps enjoy a higher degree of autonomy within the domestic sphere compared to most other parts of the country. This also applies to the group of respondents who have undergone induced abortion: if anything, they seem to do better than the rest on this score. Like other respondents, they too seem to have carved out a domestic space where they take day-to-day decisions. In this regard, it is particularly noteworthy that all 17 respondents in this category reported that they themselves take decisions that relate to seeking health care. And in terms of more important, longer-term decisions, like buying consumer durables for the household and, more importantly, decisions regarding marriage, this group has a distinctly higher, relatively speaking, degree of autonomy compared to the rest.

We have to reiterate here that this autonomy pertains to a very limited sphere within the domestic space and may not extend—at least to the same degree—to important, sensitive decisions like those relating to induced abortions. This is clear from the data given on this aspect in Table 25. Unlike decisions regarding health-seeking, which in all cases were taken by the respondent herself, in issues pertaining to abortion—whether to undergo abortion, and if yes, in which facility, etc.—only in half the cases did the respondent make the decision herself. But it is noteworthy that in all 16 cases for which we have data, the women were party to the decision-making process regarding whether or not to undergo abortion: in eight cases they decided by themselves, in six cases with their husbands, and in two with the help of other family members. Of the two cases in the last category, one took the decision in consultation with her married daughter: she had conceived after her daughter had got married and had a family of her own—a situation that she found 'shameful'. In another case, where abortion was sought for medical reasons, the decision was taken jointly with family members.

As far as choice of facility is concerned, the picture is more or less the same for all 16 respondents. The eight

Table 24: Decision-making in the Household among Respondents with Induced Abortions

Classification of respondents by status of pregnancy wastage	Day-to-day issues						Longer-term, more important issues				
	percentage where respondent took the decision herself						per cent where the respondent herself decided on buying consumer durables	decision regarding respondent's marriage (percent distribution)			
	buying daily household requirements	buying clothes for herself	buying clothes for children	obtaining health care for herself	obtaining health care for children	what items to cook		parents/ elders without consulting her	parents/ elders with her consent	herself with consent of parents/ elders	herself without consent of parents/ elders
Respondents with induced abortions	52.9	88.2	94.1	100.0	94.1	100.0	47.1	11.8	88.2	Nil	Nil
Rest of the respondents	34.7	100.0	94.3	93.8	94.3	100.0	36.8	30.2	68.8	0.5	0.5
Respondents with other types of wastage but not induced	29.1	90.9	92.7	92.7	92.7	100.0	30.9	40.0	60.0	Nil	Nil

Source: Village Survey (2002).

Table 25: Decision-making with Respect to Induced Abortions

Person(s) who took the decision	Decision to undergo induced abortion		Decision regarding choice of facility	
	Number	Percentage	Number	Percentage
Respondent on her own	8	50.0	8	50.0
Respondent's husband on his own	Nil	Nil	1	6.3
Respondent with her husband	6	37.5	4	25.0
Respondent with other members of the family	2	12.5	3	18.8
Total	16	100.0	16	100.0

Note: We could not obtain the data for one respondent; so the total number of observations is 16.
Source: Village Survey (2002).

respondents who had taken the decision to abort on their own, also decided on the facility they wanted to use. In seven cases, the decision was made jointly; only in one case did the husband take the decision by himself. The respondent, an old, illiterate person, reported that she did not know of any facility where abortions were done.

Measures and components of pregnancy wastage

A comparison in terms of pregnancy wastage reveals that its rate in the induced abortion group is slightly higher than for those who have suffered other types of wastage. The incidence of multiple wastage is also slightly higher for this group.

As for the components of wastage, nearly 80 per cent of the wastage in this group (with induced abortions) is due to induced abortions, with involuntary abortions accounting for just a fifth of the wastage. The rate of involuntary abortions is also quite low for this group: 5.1 per cent compared to 23.4 per cent for those with other types of abortions. Thus there does not seem to be any evidence that indicates that recourse to induced abortions would later lead to involuntary pregnancy wastage on any significant scale.

The other important point that the table throws up relates to the possible linkage between pregnancy wastage and fertility decline: the pregnancy rate for those with induced abortions is higher compared to the rest, but the fertility rate—based on children ever-born per woman—is lower, indicating that this group has taken recourse to voluntary abortions as a means of family limitation. The chain of causation for the group with other types of wastage seems to run in the other direction: a high pregnancy rate among them is a response to high involuntary wastage. Witness the high pregnancy rate as well as fertility rate among them.

Our discussion in this section shows that those who have gone in for induced abortions in our study village are likely to be younger, more literate, with higher exposure to mass media and urban influences and better access to non-farm employment, and more likely to be followers of the matrilineal system. They are also more

Table 26: Measures and Components of Pregnancy Wastage for Respondents with Induced Abortions

Classification of respondents by status of pregnancy wastage	Respondents in the group as a per cent of total in the sample	Measures of pregnancy wastage			Components of pregnancy			Details on those wastages by type		Fertility measures with multiple pregnancy wastage	
		Gross rate of pregnancy wastage	Net rate of pregnancy wastage	Index of vulnerability to pregnancy wastage	Rate of induced abortion	Rate of spontaneous abortion	Rate of still births	No. of respondents with multiple wastage as a per cent of no. within the group	Gross rate of wastage for those with multiple wastage	No. of pregnancies per woman	No. of live births per woman
Respondents with induced abortions	8.1	26.5	36.1	300	21.4	2.0	3.1	41.1	33.3	5.76	4.23
Respondents with other types of pregnancy wastage but no induced abortion	26.6	23.4	30.6	287	Nil	15.4	8.0	39.3	28.6	6.25	4.79
All respondents with no induced abortion	91.9	8.9	9.8	109	Nil	5.9	3.1	11.3	28.6	4.73	4.31

Source: Village Survey (2002).

Table 27: Attitude towards Induced Abortions among Respondents with Induced Abortions

Nature of response	Category of respondents by status of pregnancy wastage	Percentage who know abortion is legal	Percentage who agreed that abortion is acceptable in the following circumstances						Percentage who want that abortion should be		
			Mother's health is in danger	Foetus is abnormal	Rape	Preferred method of contraception	Failure of contraception	Premarital or extra marital pregnancies	Banned	Available at low cost	Available on demand at any clinic any time
Before discussions	Those with induced abortions	100.0	35.3	35.3	29.4	29.4	35.3	29.4	Nil	23.5	Nil
	The rest of the respondents	85.1	68.4	66.2	69.9	6.8	64.7	68.4	12.8	21.8	Nil
	Those with other types of wastage but no induced abortions	91.1	77.4	77.4	16.1	6.5	77.4	77.4	19.4	35.5	Nil
After discussions	Those with induced abortions	100.0	100.0	100.0	93.8	37.5	100.0	87.5	Nil	56.3	6.3
	The rest of the respondents										
	Those with other types of wastage but no induced abortions	85.1	95.8	95.8	96.4	19.2	93.4	92.2	1.2	44.9	8.4
		91.1	91.8	91.8	93.9	24.5	87.8	87.8	2.0	49.0	6.1

Source: VillageSurvey (2002).

likely to take recourse to voluntary abortions as a means of family limitation. These findings are the obverse, as it were, of the broad generalisation we had come to in the previous section where we looked at the rates and components of pregnancy wastage and identified the social group where the induced abortion rates are the highest. The discussion in this section also points to the relatively higher degree of autonomy that this social group enjoys. How does this group compare with the rest in terms of its attitude towards induced abortions?

Attitude towards induced abortions

Table 27, which summarises the relevant data, shows that, unlike the other respondents, *all* the respondents who have undergone induced abortions do know that it is legal. However, their responses *before* our discussions with them show their overall attitude towards abortion as much less liberal when compared to the rest, of whom nearly two-thirds appeared to hold a liberal view on various issues relating to abortion. The corresponding proportion among those with induced abortions was just about a third. As noted earlier, this difference was largely due to the fact that their responses were much more ambiguous than those given by the rest of the respondents. When we look at their responses *after* discussions, the attitude of those with induced abortions ap-

pears to be as, if not more, liberal than that of the rest. But again, as we have pointed out earlier, it is important to note that despite becoming more liberal, their views—like the others'—have not become permissive. While all of them advocate that there should be no ban on abortions, only about one in 16 would like access to them to be unfettered and free, and only 50 per cent of them want abortions to be available at a lower cost. And while all of them believe that abortion as an acceptable option in cases of contraceptive failure, only a third see it as a preferred method of contraception. The moral and maternal health considerations that seem to underlie the absence of permissiveness in the case of our other sample respondents also seem to motivate those in the induced abortion category.

But their stand against the use of induced abortions as a preferred method of contraception seems to contradict an earlier point we made: that this group in fact uses induced abortions to limit family size in a context of rapidly declining fertility. In order to study this disjunction in some detail, it would be useful to examine the reasons put forth by our respondents for taking recourse to induced abortions.

Reasons for Undergoing Induced Abortions

Table 28 below provides a brief, qualitative summary of the reasons given by each of the 17 respondents who have undergone induced abortion. In this case, we have preferred to use a 'qualitative' rather than a quantitative summary basically because the reasons underlying induced abortions cannot be comprehended in simple, mono-causal terms. The reasons that ultimately determine whether or not a woman opts for abortion are overlapping, crosscutting and complex, and are related to a myriad issues. And unless we examine this complexity, we will not be able to determine whether the

Table 28: Reasons for Undergoing Induced Abortions

Sl. No.	*Socio-Economic Characteristics of the Respondent*	*Reason(s) for Undergoing Induced abortion(s) and General Remarks*
1.	Young beedi worker from the matrilineal system; Hindu	The respondent wanted only two children and after the second child wanted to undergo tubectomy. But for this she had to take the permission of the family deity—*Naga Devaru*, the serpent god—during *darshina*, when the deity makes its appearance through the community priest (*patri*). But this permission was not forthcoming easily. By the time the permission was granted by the deity she had become pregnant and had decided to undergo abortion. After the abortion she did not undergo tubectomy, even though permission from the deity had been obtained by then, since she was under the impression that a tubectomy could be done only after a delivery. She had to undergo three induced abortions because of this belief.
2.	Young beedi worker from the matrilineal system; Hindu	Her general health was very poor and hence the doctor refused to perform tubectomy either before the conception (of the unwanted child) or after the abortion. The doctor also refused to insert an intra-uterine device (IUD) as she had white discharge.
3.	Young beedi worker from the patrilineal system; Muslim	She got married at the age of 16 and had two children before she was 18 years old. As she was less than 20 years old, the doctors refused to perform tubectomy after the second child. She was scared of using the loop and oral contraceptives were inconvenient. So the third pregnancy was aborted. Since she was still less than 20 years old, the doctors once again refused to do tubectomy. At the time of the interview she was pregnant for the fourth time and was planning to have a tubectomy done this time around as she would be more than 20 years old after the delivery. It was also suspected that the foetus was an abnormal one in her third pregnancy.
4.	Old beedi worker from	She had one male child and two female children. But the male child passed away. She conceived the matrilineal system; Hindu for the fourth time hoping to get a male child. But after conception she was haunted by the fear that either the child would be female or, even if it were male, might again not survive. So she decided not to have any more children, got the pregnancy aborted and underwent sterilisation. The respondent perhaps had some psychological problems.
5.	Old home worker from	After the desired family size of four children, she did not undergo sterilisation because she was the patrilineal system; Muslim afraid of the 'operation'. But she had five more pregnancies and after the ninth delivery, she was determined to undergo tubectomy. But she developed some serious complications after her this delivery and the doctors refused to do tubectomy. So she had three more pregnancies. At the time of her twelfth pregnancy, her eldest daughter was already married. She felt too ashamed to continue with the pregnancy. She had it terminated and then started using the loop.

(contd)

Sl. No.	Socio-Economic Characteristics of the Respondent	Reason(s) for Undergoing Induced abortion(s) and General Remarks
6.	Old agricultural labourer from the matrilineal system; Hindu	After the desired family size was attained she used oral contraceptive pills, but very irregularly, for about six months and conceived. She got the pregnancy terminated and for the last two years has been using the pills regularly. She would prefer her husband—who, she says, is a drunkard—to undergo vasectomy, but he refuses.
7.	Old agricultural labourer from the matrilineal system; Hindu	Her repeated attempts to obtain permission from the family deity (*Naga Devaru*) to undergo tubectomy failed. As she did not want more than three children, she got the fourth pregnancy terminated, but did not want to go against the wishes of the family deity and undergo tubectomy. She was also afraid of using IUD. She delivered once more since the doctor refused to abort two successive pregnancies. She had one more induced abortion, of her sixth pregnancy. After that she used oral contraceptive pills supplied by the ANM for six months. After that the ANM stopped her visits and she could not afford to buy the pills from the market. So she used pills very irregularly and conceived again twice—the first one she delivered and the next one was a stillbirth. Since she was tired of repeated pregnancies, induced abortions and stillbirths, she decided to have the tubectomy done even without the deity's permission.
8.	Old agricultural labourer from the matrilineal system; Hindu	Her husband had deserted her for six years. When he returned, she did not want to have any more children. But since she did not know of any family planning method, she did not use any and conceived. But by then her daughter had completed her family and had undergone tubectomy. So she and her husband felt ashamed and decided to terminate the pregnancy.
9.	Old agricultural labourer from the matrilineal system; Hindu	In her early reproductive years she was afraid of using the IUD and/or undergoing tubectomy. Her fifth delivery was a difficult one and she developed serious complications after that. So the doctors refused to do tubectomy. She terminated her eighth pregnancy since she was tired of deliveries by then. But she still could not undergo tubectomy as she was weak and the doctors refused to perform it.
10.	Agricultural labourer belonging to the 'other' age group and the matrilineal system; Hindu	She could not get permission from the family deity to undergo tubectomy. She was also afraid of using IUD. She did not want more than three children. So during her fourth pregnancy she consumed a large number of oral contraceptive pills to abort the foetus. When that did not work, she was afraid of the adverse consequences of the tablets on the foetus and hence went in for induced abortion.
11.	Agricultural labourer belonging to the 'other' age group and the matrilineal system; Hindu	After her third delivery, she was motivated by the ANM to undergo sterilisation. But she developed an abscess soon after the delivery and could not get the tubectomy done. Later, she migrated to a village where there was no health worker. Without the help and assurance of a health worker, she was too scared to undergo sterilisation. She aborted her next two pregnancies.
12.	Young home worker; patrilineal system; Muslim	She did not know much about family planning methods and by the time she decided on what method to use, she had three pregnancies in two years. She aborted the third and had loop insertion after that.
13.	Home worker from the 'other' age group and the matrilineal system; Hindu	She was under the impression that after delivering twins she would not conceive for some time and hence did not use any family planning method. She was also afraid of using the IUD. But she conceived again immediately after delivering twins. She felt it would be very difficult to look after three babies and decided to have an abortion. She had one more delivery and then had tubectomy.
14.	Young beedi worker from the matrilineal system; Hindu	During the early days of her first pregnancy, she suffered a fracture and had to be hospitalised. The doctors did not know of her pregnancy. When they came to know of it, she was referred to an obstetrician who advised termination of pregnancy as it was possible that the medicines used to treat her would have an adverse effect on the foetus.
15.	Young beedi worker from the matrilineal system; Hindu	She suffers from muscular dystrophy. When she got married when the disease was in remission. But it recurred during her first pregnancy and hence she went in for abortion.
16.	Old beedi worker from the matrilineal system; Hindu	When she was pregnant the third time she developed a third degree prolapse of the uterus and hence the doctors in the government hospital in Kundapura (the taluk headquarters) advised her to undergo MTP. She had an induced abortion at 14–16 weeks of pregnancy and then had a hysterectomy done.
17.	Agricultural labourer belonging to the 'other' age group and the matrilineal system; Hindu	She delivered seven daughters while waiting to have a son. By the time she was pregnant for the eighth time, she said she was tired of repeated deliveries. The fear that the eighth child might also be a female created lot of psychological stress for her. She consumed 60 oral contraceptive pills given by an ANM to abort the foetus; developed severe side-effects, she was shifted to a hospital where the pregnancy was terminated. She later became pregnant, delivered a son and underwent tubectomy.

Source: Village Survey (2002).

respondents' choice to undergo abortion was free and informed.

Within this complex of reasons if one were to look for the most important proximate cause, the likely candidate is family planning: 13 out of the 17 respondents (77 per cent) gave this as a reason for taking recourse to induced abortions. Moreover, it was resorted to after the failure of some other technique in only one case. In the majority of cases (10) it was used as a means for family limitation; only in three was it used as a spacing method. This obviously does not square with the fact that nearly two-thirds of these 17 respondents claimed to be against the use of induced abortion as a preferred method of family planning, primarily because of its negative impact on maternal health. How, then, does one explain this disjunction between attitude and practice?

In this context, it would be useful to look at the factors that underlie the proximate cause for the respondents' use of abortion, beginning with the nature of prevailing fertility behaviour and family planning practices in the region. It will be recalled that throughout this paper, we have underlined the strong linkages between fertility transition and pregnancy wastage of all types.

Rapid fertility decline in the region, particularly in the 1990s, is premised almost solely on family limitation, with next to no role for spacing or increase in age at marriage. In this context, the region exhibits strong similarities with other regions like Tamil Nadu and Andhra Pradesh, which have witnessed similar patterns of fertility transition in the recent past. And like these states, in our region too the almost universal means adopted in this transition is female sterilisation. The reasons for this are well known and need not be repeated here. But there is one point we would like to highlight in this regard: there has been very little effort on the part of the state or the public health establishment to educate the public on the various options available for family planning. Consequently, the level of public awareness on these issues appears to be very low. In fact, in our sample as a whole, only about 18 per cent of the live births were followed by *any one* instruction regarding health education or family planning practices. Even among the young respondents, where the percentage of institution delivery was 65, just about 38 per cent received such instruction. This poor knowledge of contraceptive practices appears to be one of the reasons why the use of spacing methods is low, or why the failure rate is high even when a spacing method is adopted.

Consequently, women who want to but cannot limit family size by adopting sterilisation resort to induced abortions as a way out. This is also true for those who want to adopt a spacing method but either cannot do so or use it improperly. And, as the table on reasons makes clear, there are a number of reasons why some women who want to undergo sterilisation or adopt spacing in fact cannot do so. Some of these are:

Religious: At least three of the 17 respondents either could not undergo sterilisation or had to postpone it, and hence took recourse to induced abortion. It should be emphasised here that all the three are Hindus.

Maternal health: In a number of cases—at least 7 out of 17—the reason for resorting to abortion was poor maternal health. In four, abortion was chosen because the woman's poor health did not permit tubectomy; in three, abortion was chosen without considering any other option.

Social reasons: The prevailing fertility behaviour in the region can be an important factor underlying the use of induced abortions for family limitation. Girls get married at a fairly early age and most couples attempt to complete the desired family size—mostly comprising two children—soon after marriage. If this is done before the mother reaches the age of 20, an age below which doctors often refuse to conduct tubectomy, abortion is used to terminate an unwanted pregnancy. This is aptly illustrated by the case of one respondent who completed her desired family size of two when she was only 18, and hence could not undergo tubectomy after the second delivery.

There are also other social factors that have direct impact on the choice for abortion. As in the case of two respondents in our sample, the long wait to have a child of the desired sex—male—can lead to abortion, interestingly, even in the absence of sex determination tests. So, too, can the shame a woman may feel on becoming pregnant when her daughter has also started raising a family.

Misconceptions about contraceptive practices and reproductive behaviour: These misconceptions, as the table suggests, come in a number of forms. One woman believed that she would not conceive for some time after delivering twins; another that tubectomy can be performed only after a delivery. There are also genuine

apprehensions regarding use of contraceptives. The belief that IUDs can be harmful; uneasiness at having an external object inserted in the body; fear of undergoing an 'operation'; lack of knowledge about how a contraceptive should be used, particularly the oral pill; misuse of oral pills as abortificient with adverse consequences for maternal and foetal health; lack of knowledge about different family planning techniques (their availability, use and consequences, as also their affordability)—all these are some of the reasons why unwanted pregnancies occur and abortion is necessary to terminate them.

These are just a few of the strands within the complex web of reasons that underlie the recourse to induced abortions by women. A more informed and intensive qualitative approach perhaps would unearth many more layers of the web. But even these limited findings serve to highlight two broad, general issues that we raised early on in this report. The first issue relates to the link between induced abortions and fertility decline. We noted earlier that for a section of our respondents—young beedi workers from the matrilineal background—the incidence of pregnancy wastage is low; intensity is high; a large part of the wastage is due to induced abortions; the relative pregnancy rate is high in that the pregnancy rate for the affected group is significantly higher compared to the rest; and absolute fertility levels are low. We interpreted this to mean that within this social group, a relatively small sub-group that for a number of reasons has a high pregnancy rate is likely to resort to induced abortions to reduce fertility levels. Our discussion on the reasons for abortion provide some additional support to some of these contentions: they point to the factors underlying unwanted pregnancies, as well as the reasons for recourse to induced abortions as a means to terminate unwanted pregnancies.

The second issue relates to female autonomy and abortion rights. We have argued that because of a combination of factors and circumstances, this social group—viz., young beedi workers belonging to the matrilineal system—is likely to enjoy a higher degree of autonomy, relatively speaking, at least within the domestic sphere. The fact that it is precisely the same socio-economic group which resorts to induced abortions as a means of family limitation perhaps establishes a link, we postulated, between the higher degree of autonomy and higher recourse to induced abortions. But we also raised the question as to whether such a link necessarily establishes that the choice of induced abortion by this group is a free and informed one, taken under enabling circumstances.

While the linkage between these facilitating social circumstances and abortion rights needs to be recognised and underlined, our discussion so far also points to the need to qualify it. Though the decision to abort an unwanted pregnancy, when viewed in the larger socio-economic and cultural milieu, may often be a free, preferred choice, it is a contingent one, necessitated by constricting circumstances that rule out other choices. In other words, the right to abortion has to be viewed as part of the larger set of reproductive rights, taking into account the socio-economic and cultural contexts that facilitate or constrain this larger set of rights.

But even if we were to evaluate the right to abortion in isolation, there are other aspects to it—such as access to abortion and abortion care—that would need to be brought on board.

ACCESS TO ABORTIONS AND ABORTION CARE

Table 29, which summarises the relevant data, raises some important points.

Unmet demand

There appears to be a considerable amount of unmet demand for induced abortions among our respondents. While 17 respondents have undergone induced abortion, another six reported that they wanted to undergo induced abortions but did not. The reason for wanting to abort pregnancies was largely to limit family size (three cases) or for spacing (two cases): i.e. five out of six wanted to use it as a family planning technique. However, in one case the reason was social: the respondent stated that she wanted to abort her premarital pregnancy but did not do so.

Of these six, three used oral contraceptive pills as abortifacient, which did not work in any of the three cases. Two of them later approached a doctor for an abortion but he refused since both pregnancies were already of over 20 weeks' duration. The third reported that she was afraid of undergoing an 'operation' and hence did not approach any doctor for MTP and continued with the pregnancy.

The other three did approach doctors for getting an MTP done, but were refused: in one case because it was the first pregnancy, and in the other two because the

Table 29: Some Aspects of Induced Abortions Among Sample Respondents: Access, Nature and Care

Aspect Dealt With			No. of Observations
Unmet demand for induced abortion	No. of respondents who wanted to have abortion but did not		6
	Reason for wanting to have abortion	For family limitation	3
		For spacing	2
		Because of pre-marital pregnancy	1
Latent demand	No. who would have abortion if conceived again		3
	Reason: Because the desired family size is complete		3
Nature of service provider	No. of respondents who went to an informal provider for abortion		Nil
	No. who got the abortion done by a qualified doctor		16
	Public/private nature	No. who went to a public facility	1
		No. who went to a private facility	15
Gestation age of abortions	In the first trimester	Total in first trimester	18
		Within six weeks	3
	Total no. in second trimester		3
Pregnancy order	No. of abortion done in the first pregnancy		2
List abortal care	No. who did *not* have any post-abortion care		10
	Reason for not having post-abortion care	Not necessary	8
		Did not have money	2
	No. who had medical complications due to induced abortion		1 (bleeding)
Search	No. who had to search a lot for a provider		3
Use of oral pills as abortificient	No. who used contraceptive pills as abortificient		8
	No. who bought the pills from the chemist		7
	No. who had to undergo MTP after consuming pills		5

Source: Village Survey (2002).

pregnancies were of more than 20 week's duration. Of these two, one is an interesting case where the respondent appears to have used her knowledge of abortion laws and matrilineal customs to advantage. A young and literate agricultural labourer, she did not want to abort her (premarital) pregnancy and consistently refused to do so despite the urgings of her partner, who also belonged to the same matrilineal community as the respondent. Finally, she agreed, but only when the pregnancy was advanced, knowing full well that that at 20 weeks' gestation, the doctor would refuse to conduct an MTP. Instead, the doctor and family elders advised the couple to get married, which they did—interestingly, in a civil ceremony—and the respondent continued her pregnancy. We may recall here that the *Kattu-Kattalais* of the matrilineal system take a relatively liberal view of such premarital and extramarital relationships.

Nature of the service providers

Perhaps the most striking aspect regarding the nature of service providers in our study region is the almost total absence of informal providers. Our general enquiries revealed that this group of providers disappeared from the region quite a while ago. Not one of the 16 respondents for whom have the relevant data (as noted earlier, we could not obtain the pregnancy and abortion history of one respondent who had undergone pregnancy wastage) reported that she had made use of the services of any informal provider; all of them had gone to a registered medical practitioner.

The other striking feature regarding the nature of service providers is the overwhelming presence of private facilities. Of the 16 respondents, only one had gone to the government hospital in the taluk headquarters in Kundapura; the others had all used one or the other private medical practitioners in the vicinity of the village. There appear to be three major reasons for this preference for private providers:

- The public facility was available only in the taluk headquarters, which is about 20 km away from the village. The private facilities—small 'nursing homes'—are more numerous and closer to the village.
- In the government hospital, most abortions are conducted under sedation or with local anaesthesia, whereas in the private facilities they are done under

general anaesthesia. Many of the respondents preferred the latter pain-free procedure.

- After abortion in the government facility, women are generally asked to adopt some sort of family planning method. There is no such demand made by the private facilities.
- A consequence of the almost total reliance on the formal, private providers is that it often leads to a considerable amount of searching and running around. This is largely because (private) medical practitioners often refuse to conduct MTP if they feel that it will impact negatively on the mother's health or if the pregnancy is a first one or of more than 20 weeks' duration. Three of the 16 respondents reported that the search involved in getting a provider was quite extensive. One of them was suffering from muscular dystrophy and no private provider in the vicinity was willing to perform an MTP because they feared that it might affect her health adversely. She finally had to get it done at the government hospital. The other two had more than one abortion each, and doctors in the region generally refuse to conduct repeat abortions on the same woman. So both of them had to look for new providers for the second and subsequent abortions.

Use of oral contraceptive pills as an abortificient

While there are no quacks in the region, their place seems to have been taken up by the women themselves! The practice of using oral contraceptive pills as an abortificient appears to be fairly widespread. In our sample we came across eight respondents who had resorted to this method, predictably without success. Five of the eight later decided to get the abortion done medically—one after developing severe side-effects, and another because she was afraid that the pills she had consumed would adversely affect the foetus. The remaining three respondents continued with the pregnancy.

We did not probe how this idea—that contraceptive pills can be used as an abortificient—originated and gained currency in the area. Perhaps it had something to do with the fact that contraceptive pills are commonly used to regulate menstruation. It is also possible that the perceived 'advantages' of this method—anonymity, absence of surgical procedure, etc.—have played an important role in its spread. However, the role of local chemists in this regard is unmistakable. As many as seven of the eight who resorted to this practice purchased the pills from local chemists, while one obtained them from a health worker. In a context where there are no regulatory mechanisms to oversee the sale of drugs—even prescription drugs—and where chemists often double up as doctors, it is not surprising that they are major providers of abortion services. Policy-makers would need to keep this aspect in mind before they decide to introduce RU486 into the market on a large scale.

Abortion care

One consequence of the fact that abortion providers in the region are experienced doctors in formal health facilities is that abortions of first pregnancies and those in the second trimester are rare. In our sample, there were two first pregnancy and three second trimester abortions—and all but one were performed because of maternal health considerations or foetal abnormality. In one case of first pregnancy cum second trimester abortion, the respondent was suffering from muscular dystrophy; the other case of first pregnancy abortion was because of suspected anomaly in the foetus. The second case of second trimester abortion was performed because the respondent suffered a third degree prolapsed uterus at the end of the first trimester; and in the third case the respondent had tried to abort the pregnancy by consuming oral contraceptive pills and by the time she approached the doctor for an MTP the pregnancy was already in the second trimester.

Going by the responses of our sample respondents, there appear to have been hardly any post-abortion complications. Only one respondent reported that she had continuous bleeding for five days after the procedure. But perhaps this finding needs to be taken with a pinch of salt since all our respondents belong to the poorer strata of society. Conceptions of post-abortive morbidity, as of any other type of morbidity, have a strong, subjective bias built into them, with the poor largely tending to understate its occurrence. In fact, as many as 10 out of 16 in our sample did not even have a post-abortion medical check up: eight did not see the need for it, and two did not avail of it for financial reasons.

So far we have dealt with only induced abortion, which does carry an element of conscious choice. However, there is no question of choice where spontaneous abortions and stillbirths are concerned. All the same, pregnancy wastage of the involuntary type also constitutes an important element in the context of the right to

reproductive health. A brief discussion on this issue is therefore in order.

INVOLUNTARY ABORTIONS

Involuntary abortions—i.e. spontaneous abortions and stillbirths—account for the bulk (nearly 80 per cent) of pregnancy wastage in our sample. Of the two, spontaneous abortion is the more important component and accounts for nearly half of the total pregnancy wastage, with stillbirths accounting for the other 30 per cent.

The rate of involuntary abortions varies considerably across socio-economic groups: it is higher for agricultural labourers and home workers compared to beedi workers; and it is higher among the older generation compared to the younger. The decline (from the 'old' to the 'young') is particularly sharp among agricultural labourers: for the old among them, the gross rate of involuntary abortion is 9.6 per cent, which declines to 5.1 per cent for the young. This decline, as we have already argued, is closely linked to the process of fertility decline in the region, both as a cause and a consequence. Improvements in health care facilities—particularly for maternal health—have led to a decline in involuntary pregnancy wastage which, in turn, has reduced the role of the insurance effect underlying higher family sizes. On the other hand, the spread of the two-child norm has drastically cut down the percentage of higher order births in the region, and since the incidence of involuntary wastage is higher for higher order births, this has resulted in a decline in the rate of involuntary abortions.

The counter-tendency, where a rapid fertility decline dependent solely on family limitation leads to a higher incidence of pregnancies-at-risk and hence to a higher rate of involuntary abortions—which can be observed in Tamil Nadu—does not seem to operate in our study region. This may be partly because, while the average interval between two consecutive pregnancies has certainly gone down over time, even today it is about two years for most cases in the region. This average, which is 2.5 years for the older generation, declines to 2.4 years for the 'other' age group and to two years for the young in our sample. To some extent, this relatively high interval between two pregnancies can be attributed to the prevalence of longer durations of breast-feeding in our sample—even among the young.

However, our point about the absence of the tendency of fertility decline leading to higher involuntary wastage needs to be viewed only as a broad, plausible hypothesis requiring further study. First of all, there are socio-economic groups in the region for whom involuntary wastage is still very high or has increased over time. Thus, among the home workers, the gross rate of involuntary wastage is a high 14.1 per cent among the old; and while it does decline over time, it still remains 12.6 per cent among its young. Among the beedi workers, on the other hand, this rate registers an increase over time, from 4.7 per cent among the old to 5.9 per cent among its young. There may therefore be sections in the region's population for whom pregnancies-at-risk and the consequent pregnancy wastages are still matters of concern.

Secondly, within involuntary abortions, it is only the spontaneous abortion rate that has witnessed a decline in all the three occupation groups. In sharp contrast, the rate of stillbirths has witnessed an *increase* over time. This, again, is a matter of serious concern, the reasons for which and their links to the pace and pattern of fertility transition in the region are issues that need to be further studied.

There is one more important issue that needs our attention: the plausible linkages between occupational health and the extent and nature of involuntary pregnancy wastage. Table 30 provides data on the distribution of involuntary wastages by the gestation age of the pregnancy at which wastage occurs for each of the three occupation groups. In this context, a very clear pattern emerges across the three groups, with beedi workers providing a sharp contrast to agricultural labourers and home workers. While beedi workers show a higher rate of early wastage (first trimester spontaneous abortions) compared to the other two groups, agricultural labourers and home workers show a much higher rate of late wastage (i.e. second trimester induced abortions cum stillbirths). If we take into account only the spontaneous abortions, the contrast is even sharper. In the case of beedi workers, nearly 90 per cent of spontaneous abortions occur in the first trimester; the picture is exactly the reverse for agricultural labourers. Nearly three-fourths of spontaneous abortions in the case of agricultural labourers occur in the second trimester, with the percentage for home workers, at around 80, being even higher.

Are these distinct patterns linked to the conditions of work in each of the occupations? While establishing these links beyond any reasonable doubt would need

Table 30: Involuntary Pregnancy Wastage by Gestation Age at Wastage

Occupation group	No. of pregnancies	No. of involuntary pregnancy wastages						Gross rate of involuntary pregnancy wastages						First trimester wastage as a per cent of total spontaneous abortions	Late wastage as a per cent of total involuntary wastage
		Spontaneous abortions			Still births	Total no. of involuntary wastage	Total (for all involuntary wastages)	For spontaneous abortions			Rate of still births	Early wastage rate	Late wastage rate		
		I trimester	II trimester	Total				I trimester wastage rate	II trimester wastage rate	Total spontaneous abortion rate					
Beedi workers	275	8	1	9	11	20	7.3	2.9	0.4	3.3	4.0	2.9	4.4	88.9	60.0
Agricultural labourers	596	10	26	36	16	52	8.7	1.7	4.4	6.1	2.7	1.7	7.0	27.8	80.8
Home workers	145	2	9	11	4	15	10.3	1.4	6.2	7.6	2.8	1.4	9.0	18.2	86.7
All respondents	1016	20	36	56	31	87	8.6	2.0	3.5	5.5	3.1	2.0	6.6	35.7	77.0

Source: Village Survey (2002).

considerably more research, there are reasons to believe that such links exist. Of the two patterns operating in our study region, the one exhibited by beedi workers is closer to the 'normal' one in that, generally speaking, first trimester spontaneous abortions outnumber those that occur later. *Williams' Obstetrics* in fact states that as a rule, more than 80 per cent of spontaneous abortions occur within the first 12 weeks of pregnancy (Williams and Gary 2001: 856). Since the other pattern, exhibited by agricultural labourers and home workers, is perhaps is more 'abnormal', we shall look that first.

The link between work conditions and the preponderance of second trimester spontaneous abortions among agricultural labourers is easy to explain. Not only does the work of a female agricultural labourer involve heavy tasks like carrying heavy loads, but many of them—such as transplanting and harvesting—have to be performed standing up in a forward-bending posture. By the second trimester, the heavy work and bent posture lead to continuous and increasing intra-uterine pressure, which in turn may lead to abortion. They may also put pressure on uterine blood circulation, leading to uteroplacental hypoxia and abortion.

As for the home workers, a plausible explanation for this linkage is that while these respondents identify themselves as housewives, they more often than not do a considerable amount of work either in their family farm or in their homestead or kitchen garden. The tasks they have to perform may be more desultory, but are no less strenuous than those done by regular agricultural labourers. Moreover, many of the domestic chores, like drawing water, are no less stressful than field labour and frequently require standing in a bent posture.

Among beedi workers, although the dominance of first trimester wastage is closer to the normal pattern of spontaneous abortions, the impact of working conditions cannot be completely discounted. The effect of smoking on what are called euploid abortions, which generally occur in the first trimester and peak around the thirteenth week, is well documented in the literature. *William's Obstetrics* reports that for women smoking more than 14 cigarettes a day, the risk of euploidic abortion is approximately twice that of those who do not smoke. That continuous exposure to fine tobacco dust—often in a small, closed space with no proper ventilation—has a similar effect is a plausible hypothesis. This hypothesis is supported by the fact that among the beedi rollers in our sample, those with spontaneous abortions have spent more number of years rolling beedis compared to those with other types of pregnancy wastage. The average number of years spent in beedi-rolling was 12 years for those with induced abortions, 15.1 years for those with no pregnancy wastage, 17.6 years for those with stillbirths and 20.2 years for those with spontaneous abortions.

Thus, in all the three occupation groups, work conditions seem to have some relation to the extent and nature of involuntary pregnancy wastage. This supports our earlier broad generalisation that pregnancy wastage is a phenomenon that has strong social roots.

CONCLUSION

There are two broad contentions—that pregnancy wastage is embedded in the social context of the region, and that it is linked to fertility transition—that we have made in our report. If true, then like fertility transition, pregnancy wastage should also display a wide degree of variation across space and social groups. In our study, we have found that like fertility, pregnancy wastage is also locally rooted and varies across social groups even in the same locality. Given this, attempts to comprehend the phenomenon of pregnancy wastage would be as futile as searching for general laws of population. Marx's famous dictum that 'a universal law of population exists for plants and animals only' is perhaps equally relevant for pregnancy wastage and underscores the futility of a uniform, universal policy regime to deal with it.

NOTES

1 There are only three districts in the country which have a fertility rate of less than 1.5: Chennai (1.3), Kolkata (1.4) and Leh (Ladakh) (1.3). The first two, it may be noted, are completely urban. Only three other districts—all three in Kerala—have a fertility rate of 1.5: Alappuzha, Ernakulam and Pathanamthitta.

2 Considering the sub-groups by occupation and family system and excluding the patrilineal agricultural labourer group (i.e. with n=5), the coefficient of variation (CV) for gross percentage rate is 12.4 per cent; for net wastage rate 13.8 per cent; for incidence 24.0 per cent and for vulnerability index: 33.1 per cent. The corresponding values for classification by occupation and age (with 8 observations, leaving out home workers in the 'other' age group) are 31.8 per cent, 35.0 per cent, 36.8 per cent and 52.4 per cent. The CV for pregnancy rate is 22.8 per cent for the first group of classification and 38.8 per cent for the second. The CV for fertility rate is 21.6 per cent and 39.2 per cent.

3 The relevant correlation coefficients between pregnancy rate and the different indices of pregnancy wastage are the following. For occupation—family item wise classification: 0.87 (gross rate), 0.87 (net rate), 0.84 (incidence) and 0.98 (vulnerability index). For occupation—age group wise classification, the corresponding figures are 0.07 (gross rate), 0.05 (net rate), 0.78 (incidence) and 0.84 (vulnerability index).

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